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MEDICARE: PHYSICIAN PAYMENT OPTIONS

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MEDICARE: PHYSICIAN PAYMENT OPTIONS

FRIDAY, MARCH 16, 1984

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to notice, at 9:40 a.m., in room 628, Dirksen Senate Office Building, Hon. John Heinz (chairman) presiding.

Present: Senators Heinz and Burdick.

Also present: John C. Rother, staff director and chief counsel; Barbara Krimgold, professional staff member; Isabelle Claxton, communications director; Roberta Lipsman, minority professional staff member; Robin Kropf, chief clerk; and Paula Dietz, Kate Latta, Leslie Malone, and Cindy DeAngelus, staff assistants.

OPENING STATEMENT BY SENATOR JOHN HEINZ, CHAIRMAN

Chairman HEINZ. Good morning.

Today, the Senate Special Committee on Aging continues its hearings on the future of medicare. This morning we will focus on payments to physicians under medicare.

To date, Congress has focused almost exclusively on medicare's hospital insurance program, also known as part A, when we have been considering medicare financing reform. The supplemental insurance program, or part B, which is the primary insurance program covering physician services expenses for Americans 65 and over, has not been subject to the same kind of scrutiny.

The part B program—which will cost $25 billion in 1985—now represents about one-third of all medicare costs. It is also the most rapidly growing major domestic program in the Federal budget: Cost increases in part B are more than three times the inflation rate. Next year it will become the third largest Federal domestic program—larger than food stamps, unemployment insurance or medicaid. Only social security and part A of medicare will cost the Federal Government more.

Clearly, we need a better understanding of how we reimburse physicians under medicare, and how physicians are responding to current reimbursement incentives. We also need to understand what options are possible to slow the growth of these costs.

When Congress enacted medicare's prospective payment system for hospitals under part A last year, it began to address hospital cost increases in a new and dynamic way. Rather than reducing payment for hospital services by some arbitrary percentage rate, the new DRG system established incentives to change hospital behavior. In order to be successful under this new system, hospitals must provide services more efficiently, at lower cost, and only when necessary. Hospitals, in other words, are put at risk under the new DRG payment system.

We now need to find a counterpart system for physicians under part B of medicare. Such a system must address the existing incentives in medicare's current fee-for-service method of reimbursement, those that reward physicians for providing excess services. We need to find incentives for physicians that will reduce costs while preserving quality care at a fair price.

Direct costs of physician services represent only about a quarter of all medicare costs, but doctors' decisions about the care needed by Americans 65 and over determine virtually all of medicare's expenditures. Changes in physician incentives would and could, as a result, have a major impact on all health costs.

Today, we begin to search for solutions. Our first witness will examine current and proposed physician reimbursement systems, their incentives, and physician responses to those incentives. Then, we are going to have a panel of witnesses who will look at current legislative responses aimed at controlling physician costs.

Finally, we will consider the long-range policy options designed to change physician incentives and behavior.

We have a very distinguished panel of witnesses today. We look forward to their testimony.

Let me announce that the committee is releasing today a new committee print which is available. It is entitled "Medicare: Paying the Physician—History, Issues, and Options."

Copies will be available immediately after the hearing.

But before I call on our first witness, let me turn to Senator Burdick and ask if he has any opening statements.

Senator BURDICK. I yield my time to the witnesses.

Chairman HEINZ. The witnesses and I are deeply grateful. Before we do hear from the witnesses, I am informed that three members of the committee who normally would attend today's hearing, cannot be with us due to prior commitments. They have submitted statements for the record, and without objection, I will now enter into the record the statements of Senators Charles H. Percy, John Glenn, and Lawton Chiles.

[The statements of Senators Percy, Glenn, and Chiles follow:]

STATEMENT OF SENATOR CHARLES H. PERCY

Mr. Chairman, I want to commend you for holding this hearing to consider options for changing the method of physician reimbursement under medicare.

The soaring cost of health care ranks among this Nation's gravest problems. According to the Department of Health and Human Services, an estimated $322.4 billion was spent on health costs in 1982—an average of $1,365 per person. While the Consumer Price Index climbed 3.9 percent, medical costs rose 12.5 percent. Physicians' services, which represented 19.2 percent of national health expenditures in 1982, experienced more than a sevenfold increase from 1965 to 1981. The elderly have been particularly hard hit by these rising health care costs, because on the average they use more health care services than the rest of the population.

There is no question but that the economic status of today's elderly has improved from what it was 10 to 15 years ago. In my own State of Illinois, for example, the number of elderly poor living in the State fell a sharp 43 percent, to about 141,000, between 1970 and 1980. In contrast, the number of people 65 and over living in the State was increasing by about 15.4 percent, to almost 1.1 million.

However, during the last few years, out-of-pocket health care costs to the elderly have increased even faster than their income. Seniors today are spending more than

$1 out of every $7—15 percent of per capita income—for health care. We must not force senior citizens to spend even more of their limited income for health care.

One major component of health care costs is physicians' services. medicare calculates Physicians are currently paid through the supplementary medical insurance program (medicare part B), which is funded through a combination of premiums paid by elderly persons and general revenues moneys. Medicare part B has been growing extremely rapidly—as fast or faster than the hospital insurance program (medicare part A). The growth in medicare part B is now 16 percent, and is expected to grow at four times the general rate of inflation in the future.

Who pays for these ever-rising physicians' services? Beneficiaries are now liable for over 60 percent of physicians' charges. These rapidly increasing physicians' costs have resulted in dramatic increases in out-of-pocket costs for the elderly. Only about 52 percent of all claims submitted to medicare are submitted by physicians as "assigned" claims. In addition, only 20 percent of physicians accept assignment in all cases. If the physician's actual charge for the service is more than medicare pays—as it frequently is—and the physician does not agree to accept the medicare program's allowable charge as full payment, the medicare beneficiary must make up the difference—in addition to paying premium and deductible charges. Medicare's allowable charge limits are now exceeded in about 85 percent of claims, and in 1982, "disallowed" amounts averaged $28 per bill. Unfortunately, beneficiaries have relatively little control over the services rendered or the costs of those services.

It is time that we examine this medicare program to determine what is going on under the present system of physician reimbursement, why costs are so high, and what alternatives are realistically available to hold down rates of increase. We must insure that any controls on payments do not simply shift more of the costs to medicare beneficiaries and other patients.

I look forward to learning what the options are for removing the current disincentives for physicians to help hold down health care costs and moving toward curbing the unchecked growth in the entire health care field.

Thank you, Mr. Chairman.

STATEMENT OF SENATOR JOHN GLENN

Mr. Chairman, less than 5 months ago, the Senate Special Committee on Aging heard testimony about controlling health care costs. The experts who came before us in October left little doubt concerning the urgent need to modify our current health care financing system. It is appropriate that we continue our investigation of these costs and of methods for controlling them, while at the same time ensuring access to appropriate medical care for all Americans.

Today's hearing offers us the opportunity to explore methods for controlling costs of physician services, which are a very important part of our health care system. Nearly one-quarter of all medicare expenditures are paid to physicians. This represents about $20,000 for every doctor in this country each year. It is a sizable and growing portion of medicare spending.

From 1974 to 1980, medicare outlays increased at an average rate of 16.1 percent per year. However, the outlays for the part B supplementary medical insurance program (SMI), which covers physician care, grew at an annual rate of 18.2 percent. By 1985, expenditures for part B alone will surpass $24 billion.

The Federal cost for physician services is indeed large. Unfortunately, as large as it is, the Federal portion does not represent the entire cost. Unlike reimbursement for hospital services, medicare calculates physicians rates which it considers reasonable, and it reimburses for 80 percent of this reasonable charge. The individual recipient must pay the 20 percent difference for medicare's reasonable rate as well as any additional cost the doctor charges above this rate. About one-half of all doctors' fees exceed the reasonable charge limit, on an average by 27 percent. The elderly are therefore responsible for the annual deductible, a monthly premium, a 20-percent copayment per visit, and the remaining differential between the fee the physician actually charges and the Medicare rate limit.

While I applaud the AMA's recent decision to encourage all physicians to freeze their fees, I remain concerned about the continued burden that many older people must bear in order to receive necessary professional health care. We must consider ways to control the out-of-pocket expenses for medicare beneficiaries, while at the same time encouraging the continued participation of our medical professionals in this program. We must also work together to establish a health care system that is responsible to our citizens, but one that is also affordable for the nation.

I look forward to hearing from today's witnesses. Your testimony will be valuable in leading us to solutions that are responsive and realistic.

Thank you Mr. Chairman.

STATEMENT OF SENATOR LAWTON CHILES

This is a very timely hearing. How medicare pays physicians, and how much, is quickly becoming a central topic of congressional debate.

It is also very appropriate that the Special Committee on Aging examine in depth all the options we have before us as we move to reform medicare payments to physicians. Any step we take will have major impact on the almost 30 million elderly and disabled who depend on medicare for vital health services.

It is inescapable that Congress will have to make changes in medicare physician reimbursement. The medicare part B program is just growing too fast to be able to sustain its costs. The rate of growth has been at about 20 percent a year in recent years—and it is still projected to increase at about 16 percent a year even after some of the belt tightening which has already occurred.

I think that we are all beginning to recognize that physicians, as a group, have the most to say when it comes to controlling health care costs. Decisions about medical procedures and treatments, frequency of contact and hospital admissions, and length of stay are made by physicians—not by patients.

We have alredy taken steps to tighten up on medicare hospital reimbursements, and hospitals are going to need all the assistance they can get from their real clients—the physicians—to help them meet cost containment goals.

The challenge for us will be to find a way to make reforms in the medicare part B program in a way that will protect all medicare beneficiaries from large increases in their out of pocket costs—as well as to encourage the continued full participation of physicians in the program. Access to a broad range of medical care also needs to be protected.

This hearing gives us a chance to examine a wide range of options in light of these goals, and I look foward to the testimony.

Chairman HEINZ. Our first witness is Prof. Uwe Reinhardt, departments of economics and public affairs, Princeton University, Princeton, N.J.

Although you apparently did not have to bear the cross of having to go to Yale and Harvard like I did, we nonetheless welcome you.

Mr. REINHARDT. Thank you, Senator Heinz. I did graduate from Yale Graduate School.

Chairman HEINZ. You bear up well under the strain.

STATEMENT OF UWE E. REINHARDT, PRINCETON, N.J., PROFESSOR OF ECONOMICS AND PUBLIC AFFAIRS, WOODROW WILSON SCHOOL, PRINCETON UNIVERSITY

Mr. REINHARDT. My name is Uwe Reinhardt. I am a professor of economics and public affairs at Princeton University, Princeton, N.J.

Much of my research during the past decade has been devoted to health services research and to the analysis of health policy.

I would like to thank you, Senator Heinz, and your colleagues for inviting me to comment on the issues of physician compensation. I have long had a professional, academic interest in that subject matter and I feel honored to share my thoughts on the issue with you and your colleagues.

Now, I am aware of the excellent background paper Lynn Etheridge has written for this committee, the one you just showed us. And that paper is so thorough in its pertinent data I will not have to provide additional data. I want to provide the conceptual framework, to play the egghead. And that is exactly what I propose to do.

My written statement has two major parts. One is a conceptual review of alternative approaches to physician reimbursement, how should one think about this. And second, I do have some thoughts on reforms now before you.

My overall recommendation in a nutshell would be that as a Nation we should pay our physicians well, but do so wisely. I say, "Let us pay physicians well, but wisely, because there is a certain degree of envy of physicians' income." They think it isn't really as important how much our physicians make as what we get in return for paying them. And that is really the important issue.

It is, of course, also important that we worry about how the payment we make to physicians is distributed over the rest of society, that we do not saddle the aged. I think it is true that few countries on earth saddle their aged with as much health care expenditures as we do in the United States.

It will be my view—and I want to say at the beginning—that a decent society makes healthy and well-to-do people pay for its sick and its poor. And that is a premise we should always keep in mind.

Now, on the conceptual issues, we always talk about physician reimbursement, and that denotes the notion that physicians are just compensated for expenditures they have. I would say that is a bad name. You should also talk about physician compensation or payment. We are talking about paying a wage to physicians and what should that wage be, how high should it be, and then how shall we pay it, what should we base it on? Should we base it on the physicians' work or on the output they produce?

The latter is not unimportant because how we pay people affects their behavior. That is true even of physicians. I know we professors, for example, are dedicated and noble. Everyone knows that. And I assume that physicians too have a professional ethic that drives them. Still, how we are paid as professionals does affect our behavior.

Now, the first question is: What is actually a reasonable pay for physicians? How would one think about this?

First of all, let us look at what physicians do receive. They now receive about 1 out of every 5 health care dollars, as you mentioned, about 20 percent. It is a total of $62 billion, probably now $65 billion, maybe $70 billion. I always have to remind myself how much that is. That is 70 with nine zeros to follow. It seems like a lot.

But we must not forget there are many physicians, and they serve 200 million people. And we really should look at how much is that per capita or how much is it per physician?

I have provided in my statement, after page 5, a frequency distribution that shows what America's physicians are paid, on average, and also distributes it by income class.

For example, our specialists, 5 percent of our physicians in 1981, earned more than $200,000 net per year. If you break that down by specialist, 16 percent of radiologists earn more than $200,000 a year. In fact, you will typically find that specialists who work in well-insured areas earn considerably more than physicians who work in areas where insurance coverage is not as complete.

The interesting thing is to convert the payment of physicians into hourly payment. That I have got on table 2. And the numbers there are as good as the sources I use. The sources I used were the socioeconomic service of the American Medical Association, probably the best data around in this area. And I took the physicians' average gross income, average of all physicians in the United States, and divided that by the total hours physicians report to spend in patient care, which is 51.

Now, of that 51, they will probably be spending 35 to 40 hours in direct patient contact. The other 10 hours are not seeing patients, but still working patient care. And you can see when you do that, you come to an average of $75-per-hour per physician over all specialties, although pathologists earn $102, surgeons $97.

And I would say as a rule of thumb they earn somewhere between $70 and $150 an hour, depending what hours they work, where they practice, and so on.

How should one react to such a number? And there are two standards you could use. One is the standard of comparable worth, and the other one is my kind of approach, supply and demand. And I would like to comment briefly on that.

If you took the standard of comparable work, which, for instance, the women's movement would like to see used in assessing women's pay, then we might look at similarly educated people, what do they earn? And this is interesting when you do that. Compare the earnings of a physician with that of a Wall Street bond lawyer. And that is fairly routine work. They would say physicians are underpaid. If you compare that to tax lawyers, physicians also must feel underpaid. And particularly so because tax lawyers only redistribute income, they do not produce generally any net additions to total social output. They only make sure their clients benefit at some other client's expense, while physicians do add to the net social product.

Chairman HEINZ. The Senate Finance Committee just having produced a $50 billion tax bill last night, even those of us who are not tax lawyers simply succeeded in redistributing income. We did not produce one additional dollar for society.

Mr. REINHARDT. Well, exactly.

Chairman HEINZ. Just more for the Federal Government.

Mr. REINHARDT. Thank you for that addition. That just shows physicians, when they look at other professions, can really claim they are not overpaid.

Of course, there are eminent scientists who make less than physicians, philosophers, mathematicians. And according to them, physicians could be overpaid. And that is why I am nervous about the theory and I am more comfortable as an economist with supply and demand.

And there you would say the physician is adequately paid if the payment elicits an adequate number of these professionals. If there is a nurses shortage, you may say nurses are underpaid. If there is a physician surplus, like in San Francisco, you must say physicians in San Francisco must be overpaid. And that is a much more comparable standard because we use that for everyone else in society.

And I would say, overall, physicians in America are certainly adequately paid and conceivably somewhat overly paid.

Now, the second question I raise is the basis on which you pay physicians. How should you think about that? We can either pay physicians by input, by hour work, which could be an hourly rate or salary, or we could pay them by output, which might have three different measurements. One is the individual procedure, fee for service, or the individual case managed, which would be DRG reimbursement, or the third one would be the patient treated in continuing care per year, which we call capitation.

Now, on table 3 of my paper, following page 12, I tried to summarize the advantages and disadvantages of each of these methods. And it emerges—when you think about it, there is no clearly dominating uniquely superior method for physician compensation. Each of these spaces has strengths, and each of them have weaknesses.

For example, fee-for-service has the advantage of adjusting automatically for case mix complexity. The provider's award is closely linked to output of services, which we like in our society. Patients have economic clout over a physician. If they do not like him or her, they can just not go there.

Fee-for-service provides transparency. That is often overlooked. With fee-for-service, the physician has to report to us what he or she actually does for the patient. And it is widely used and tried, and that is another advantage. At least, we do know how to use and apply fee-for-service.

The disadvantage is that there is a tendency to overservice the patient. Fees may not stand in constant proportion to cost.

And then you have highly profitable procedures and those that are lesser, which is likely to distort the practices of medicine, too many procedures are used, not enough intellectual contact with the patient.

And there is an inflationary tendency of every physician for decomposition of treatments. Following witnesses will allude to that. And it is difficult to know ahead of time how much it is going to cost you.

So those are the disadvantages of fee-for-service. And if you run through the other methods, the case or the capitation, capitation is really just sort of a sloppy DRG method where you throw up your hands and say, "I really cannot distinguish one case from another, so I just say every case is like every other average," and you call it capitation.

So the two are really in a way the same.

But whenever you use those kinds of methods, the advantage of it is that it forces the physician or gives him or her an incentive to minimize the cost of the treatment. But, in fact, the physician may minimize to the point of underservicing, that once a physician gets the payment by case or per quarter, then, of course, the physician can make money by not treating the patient, by not doing tests. And that is a disadvantage of these types of payments.

Furthermore, in the case of DRG—you will hear much more about it later—it is very difficult to slice a physician's work into distinct cases, particularly with the aged who often have multiple diagnoses. It is hard to use.

Many people advocate salary as the ideal method, using salaried physicians. I would think that a simple and naive view. When you salary a physician, you have not taken money out of medicine, you just put it in a different way. And you put it in in a way that is not advantageous to the patient. If you really want to know how salaried medical practice might work, you might look at the salary pedagogic group work, otherwise known as university teaching. And we have extraordinary leeway with students. And the students——

Chairmam **Heinz**. Do you underserve students?

Mr. **Reinhardt**. I personally do not. But my colleagues know what I mean. Not at Princeton either, but at other colleges. There are some problems.

When you use salary, you must have a good monitoring system. We at Princeton—and I am sure at Yale they do it too—have student evaluations after every course. And that does keep us on our toes.

But when you have salaries, you must monitor patient satisfaction or student satisfaction. So salary has its administrative simplicity, it does take money out of each treatment, and it gives the physician an incentive to be only a professional. But there are problems there too, and that is that physicians might neglect the patients or treat them as an account.

Now, in the third part of my paper I describe the pros and cons in greater detail and do not want to go into that now.

The third one is what I want actually to do in this Nation in the next few years. And there, it seems to me, one might attempt to experiment with DRG's. For example, one could use the DRG mechanism for pathologists, anesthesiologists, and radiologists, where you would figure out in an inpatient treatment what is actually the contribution of these physicians, pay the hospital adequately for that contribution, and then let the hospital put out that work under a competitive bid. That would be the All American market approach to this as any other contractor works, as a building contractor would work.

So, in some areas, DRG's could be used: But I am not so sure it is advantageous across the board. I would rather propose to improve the fee-for-service schedule system we now have by working toward a schedule that would be negotiated with physicians and that would be applied with mandatory assignment as a long-run goal.

In the short run, for example, one could freeze the prevailing fees now. After all, they have been paid. One could use either mandatory assignment or a voluntary assignment system with an adequate system, for example, a hotline in aging to call to find out who in their areas does take assignment, and profiles for every physician to see how many procedures does this physician use on average.

Every nation, West Germany, France, Canada, uses such profiles. It is easily done. They have an effect of controlling the quantity and price. And I think given that, we have so much experience in other countries and how to use fee-for-service with monitoring, I think that is where I would look at it as a practical matter.

Thank you.

Chairman **Heinz**. Thank you very much, Dr. Reinhardt.

The one issue, it seems to me, that is your final prescription, your final RX, which is to refine the fee-for-service system and improve building on our and other people's experience. This might come to grips with the effect of physicians' behavior, that is to say, their influence on increasing other costs, especially hospital costs.

They are the people who determine what services people get in hospitals.

And indeed, under the present system, sometimes the more services they order, the more they get in pay, and so forth.

How can you define a fee-for-service system that also controls that?

Mr. **Reinhardt**. Frankly, I don't think that is easily done in our context. It has been attempted in Germany, for example, under the so-called Bavarian contract, where physicians do get paid fee-for-service, but the insurance carriers negotiated with the physicians an overall cap. And they told the physicians, in effect, that if you hospitalize less and prescribe fewer drugs, we will let your fees go up commensurately because the insurance carriers said, "We really do not care how it is spent, we do care how much we spend." And if you spend less on hospitals, you can keep the difference.

That is turning an entire State into a joint HMO. So far the results on this are mixed. I do not think it has been sufficiently, vigorously applied.

The alternative would be really HMO, comprehensive prepaid capitation. But you are quite right, I cannot think of a fee-for-services system that actually could give the physician an incentive not to hospitalize or not to refer to a specialist.

Chairman **Heinz**. One of the witnesses we are going to hear later will testify to physician behavior under the hospital cost controls, and health care cost controls during the wage and price controls of the Nixon administration. The testimony would appear to support the point that while physicians' fees were frozen, physicians incomes nonetheless fared very well because rather than make it up on rate, they made it up on volume. And they somehow managed to find a way of delivering more service, leaving open to question whether it was needed or not. And as a result, physicians' incomes rose while everybody else's was more or less frozen. How does a good fee-for-service system, your preferred choice, deal with that problem? Or should we not be concerned about it?

Mr. **Reinhardt**. No; you should be concerned about it. And it is a safety valve that has been used by physicians worldwide.

And the way one deals with it is as follows: One does convey to the profession a notion of overall cap. And say if you overprescribe or your utilization goes up, we will simply reduce the fees proportionately to keep the total budget constant. This is what is done in West Germany. They have—and the way it is actually—the medical profession itself that is asked to administer it, they are essentially playing a zero-sum game with each other. They run the profiles on their colleagues. And a colleague who is an extensive prescriber of lab tests or X-rays will have his or her fees reduced by the medical profession to whom the insurors turn over the money.

So economically that money can be dealt with through physician profiles and monitoring. And they do this in Canada in a different way. But you can call in the high prescribers and point out to them that they are taking from their colleagues rather than the taxpayer.

Chairman **Heinz**. Well, let me try and get some additional ideas from you. You took a considerable amount of time to explain that the market mechanism for physicians may not be working too well for a variety of reasons. There certainly seems to be an ample supply of physicians. Yet physicians' incomes do not seem to reflect the fact that there is an oversupply, by most estimates, of physicians, presumably because of the way licensing works, presumably because of our Federal payment system.

If you said you would like to see the payment system refined, make it more rational, what are the two or three most important things that we should do?

Mr. **Reinhardt**. Well, I think to make it more rational, there should be some proportion between the fee payment for a procedure and the cost of producing that procedure. And one of the strange features of our UCR system is that when a new procedure comes in, and you are high on the learning curve, say coronary bypass, or any other procedure, we then price that procedure. And physicians learn how to do this more cost effectively. But the fee does not go down; in fact it goes on up.

Chairman **Heinz**. We did a very comprehensive study of a pacemaker operation, which formerly was an open-chest operation, but no longer is. Yet the fees are based on the lengthy, time-consuming risky procedure of 10 years ago.

Mr. **Reinhardt**. I agree. It would be very difficult to defend the prevailing UCR fees with appeals to reason. They are haphazard. They came about through different learning curves, different degrees of political clout, or plain chutzpah in billing.

Chairman **Heinz**. Is that a medical term, chutzpah?

Mr. **Reinhardt**. So in that respect, I fully agree with you. One ought to have some proportion between fees and time spent. And one ought to have some translation of what hourly income does a particular fee imply? For example, for cataract surgery, which is not highly mechanized, the fee might imply a very high hourly rate. And this is, of course, one problem. We seem to have a lot of surgeons, and yet they are so very high up on the list of earners.

Chairman **Heinz**. So one thing we could do is go back and recalibrate existing fees using the length of time spent on a procedure as one and perhaps the most significant measure.

Mr. **Reinhardt**. I think so; yes.

Chairman **Heinz**. Now, you made some comments about experimenting with DRG's for what I took to be hospital-based physician services. Do you believe that that would be feasible, that DRG payments would be feasible under those circumstances?

Mr. **Reinhardt**. I think, by and large, it should be technically feasible to do that. I think for most cases the input by radiologists, anesthesiologists, and so on, is fairly standard. And one could allow for some outlays that could be monitored. But at least in that one area it is technically feasible to calculate what physicians contribute, and the mechanism of payment is fairly easy. All that work is done in the hospital. Therefore, it makes sense to pay the hospital, and then let the hospital bid competitively as it bids for any other input.

I think if you wanted to experiment with DRG's, that is where you might start. And if you look at the income of radiologists, of these hospital-based physicians, anesthesiologists and pathologists are very high. And they are very high for one reason, and that is they have a franchise in the hospital which has never been competitively distributed.

Chairman HEINZ. Now, your third alternative that you mentioned conceptually was capitation. What would it take conceptually to make capitation work on a national basis?

Mr. REINHARDT. It would take, first of all, the courage to look the American people in the eye and say, yes, we will have a "two-track system," that would be a nice term, or some people would call it two-tier system, that is clearly what the agent and the union would call it, and that would be that for publicly financed patients, we the Government will put out the care to competitive bidding on a fully comprehensive prepaid basis that has been attempted in Arizona.

I am told the Arizona experiment had some problems. They were, however, I am told, not conceptual but administrative. That could be done where you could say, "We purchase as the Government 40 percent of the health care delivered in America, and we want to negotiate the price, in fact we want to put it out to competitive bid."

However, that would mean that you would limit the choice of the agent among physicians and hospitals that would belong.

So this is really an issue not of technical feasibility but of political courage.

Chairman HEINZ. Does not the same risk exist now with the fact that medicare is really only a payer, and one of the largest but still one of many minority payers compared to all the others with respect to hospital expenditures? It seems to me it is possible that if the Federal Government sets too tight a set of reimbursements for DRG's, that that too could lead to a two-track system.

Is that likely?

Dr. REINHARDT. Absolutely.

I cannot imagine how a hospital administrator in the long run could give unreimbursed health care if, as you say, the Government does not cover the costs with its DRG. And as General Motors and the other great business firms ultimately refuse to accept the cost shift. Then they will ultimately have to price closer to costs, and the agent would receive different care. And if I were a hospital administrator, I would ultimately have to be driven to that point.

Chairman HEINZ. Is there anything we can do about that dismal possibility?

Dr. REINHARDT. Well, other than monitoring closely what is happening—and I think such things can be easily monitored—and setting the DRG rates reasonably high, in other words, do not do what you did in medicaid, where I think the fees were set too low, if you pay the hospitals adequately, they will probably—a little bit of cost shifting everyone will tolerate, but not a lot. I think the degree of cost shifting this society tolerates, we call it cross-subsidization, I think we have reached the limit.

Chairman HEINZ. One last question.

Physicians are the key to controlling costs in hospitals in particular. Other than the cap which may be a very good method that you mentioned, are there any other methods to provide incentives to help insure that physicians help us hold down cost increases in health care overall?

Dr. **Reinhardt**. Offhand, it is hard to think, other than some form of capitation, if you have a financial incentive. You could conceivably appeal to the physicians' ethics and citizenship. And that might buy you something. I am not sure.

As an economist, I am taught to think it would not buy you anything. Money is the only thing that buys anything.

Chairman **Heinz**. That is why they call economics the dismal science.

Dr. **Reinhardt**. I think we ought not to squeeze physicians too much fiscally. How much they make is not nearly as important as what they do in prescribing services. The only mechanism we have been able to think of is either do the cap as they use in Germany or to use some form of capitation when the physician is at risk when he or she overprescribes.

Chairman **Heinz**. Let me yield to my friend and colleague, Senator Burdick.

Senator **Burdick**. Thank you, Mr. Chairman.

Welcome to the committee.

I was going over your table 2, the average hourly compensation for physicians.

I just want to say that if my constituents from North Dakota saw that hourly rate, it would probably increase the instance of heart attacks.

What has been done to bring costs down?

I will give you one area. The doctors will tell you when you talk to them about costs, they say, well, we have so many threats and actions of malpractice, we have to buy some high-priced malpractice insurance. And that contributes a great deal to overall costs.

Have you ever done a study on how much the malpractice premiums add to the physicians' costs?

Dr. **Reinhardt**. Well, I have on page 5, the average physician—or is it page 4—out of total professional expenses of $78,000 for all specialties, malpractice is $5,800, so considerably less than 10 percent. But it varies quite enormously by specialty.

If you go into obstetrics, it is very high.

Senator **Burdick**. Using a rule of thumb, then, about 10 percent of the physicians' costs are due to malpractice?

Dr. **Reinhardt**. On an average. But I will warn you that for orthopedic surgeons and obstetricians, it is considerably higher because the probability of suit is so much greater. And then for pediatricians and general practitioners it is much lower.

On the average, however, it is less than 10 percent.

Senator **Burdick**. And have to put into your calculations the amount of overuse is caused by the doctor himself, to set up a defense to possible suit in the future, in taking too many procedures, too costly procedures, just as a matter of defense, which really are not necessary?

Dr. **Reinhardt**. I personally have never done such a study, nor am I aware of one. The difficulty here would be to identify how much of a particular battery of tests can really be accounted for this. You would have to ask the physician. And he could always say the bulk of it was defensive medicine. So it would be very difficult, actually, to get accurate information on that.

Senator **Burdick**. I talked to doctors, and they tell me, frankly, "We have to buy this insurance, and have to take extra procedures. Instead of taking five X-rays, we take 50, just to make sure of a defense in case a young lawyer is going to sue me."

Dr. **Reinhardt**. It is in my mind true, and for some professionals doubly true. And in obstetrics, I think someone told me, in some States 25 percent.

Senator **Burdick**. You have a law school at Princeton; don't you?

Dr. **Reinhardt**. No.

We were wise enough not to have one. Because there is an excess supply of lawyers, and they, too——

Senator **Burdick**. Have you ever discussed this practice with the legal profession in some form?

Dr. **Reinhardt**. Yes.

Well, the legal profession takes the view that a citizen has the right to seek compensation if he or she feels they have been harmed. And they consider they are doing society a great service.

The interesting thing to study is that other countries, Canada, Germany, have so many less malpractice litigations. For example, it is certainly true that a patient who has been harmed should be helped by society not only for pain and suffering, but to particularly—through income loss. But we could do that through some form of analog of workmen's compensation.

But in our society, the only way to help a patient who has suffered as a result of medical intervention is to sue the doctor. And so you sometimes have to sue a doctor when you feel in your heart he or she did they best they could.

And I think it is an unfortunate way to compensate patients. So the objective should really be in the first instance to compensate patients.

Senator **Burdick**. Of course there are a lot of lawsuits. I presume most of them have merit. You have always got those without merit that cost money, too.

Dr. **Reinhardt**. Yes, indeed.

Senator **Burdick**. I think it is worth exploring, because as you say it adds 10 percent to the medical costs, so it is considerable.

Dr. **Reinhardt**. It is a considerable item, yes, and particularly in the specialties for the aged. It is probably higher than 10 percent if you look at orthopedic surgery.

Senator **Burdick**. Thank you.

Chairman **Heinz**. Senator Burdick, thank you.

As I listened to you, I could not really think of filing suits with or without merit. Lawyers are grateful for both of them.

Senator **Burdick**. Some.

Chairman **Heinz**. Dr. Reinhardt, one thing you said—I was trying to find it in your testimony—by the way, we will put your entire testimony into the record as it is given in full—but you made a comment about the idea of a negotiated fee schedule. Could you elaborate a little on that. If I understood you correctly.

Dr. **Reinhardt**. Yeah.

In all countries that use fee-for-service—and the leading ones are Canada, France, and West Germany—negotiations over fee schedules proceed at two levels. First of all, relative value scales are negotiated. And that is often done nationwide and on the basis of scientific research of the relative costs of procedures, and negotiated within the profession. What is particularly important is to get physicians themselves around the table and to have someone who bills $800 an hour justify that to someone who bills only $50 an hour, to have the physicians justify their fees to one another, as they never had to before.

Negotiations bring that out in establishing the relative value scales. Once you have the relative value scales, which are updated annually in the light of new medical progress and learning from experience, then points, the dollar points that you put on the fee schedules, they are negotiated between insurance carriers and the medical profession.

In most countries, the medical profession has, essentially, unions. In Canada, there are unions of physicians with leaders who negotiate that with insurance carriers. In Canada, the Government; in Germany, insurance pools.

The problem here, to do it overnight is, we have never thought, although some of us have pleaded for a decade, that physicians should think about who can negotiate on their behalf. We would have to think about it. We have known this, that we needed to do this for a decade, and have sat on it.

Chairman HEINZ. That is what I was going to ask you.

Knowing the morass of what is essentially a State-by-State organized profession, how would you ever get from, you know, point A, which is America, to point B, which would be what you have just described? You are saying it is not easy to get there.

Dr. REINHARDT. It is not easy, but not impossible.

However, the medical scales, the medical practice is very much the same in the United States. The relative value scales could be fairly nationwide. So you would not have to do that 50 times over. And then the absolute values will be negotiated on a medical system, perhaps with rural/urban differentials to account for costs.

Most countries do not bother to make the urban/rural differential. In Canada, they do not; in Germany, they do not; here we might want to do that.

But you could use a two-tiered thing, a nationwide relative value scale supported with all the scientific capability we have, and then point negotiations on a State level. It could be done.

Chairman HEINZ. Granting that it could be done, what, in addition to achieving some kind of a production function through the negotiation, what would be the other likely results, systemic results? For example, one thing that comes to mind is the unionized profession. Is that likely to be a side effect?

Dr. REINHARDT. Yes, yes.

Chairman HEINZ. Are there any other side effects?

Dr. REINHARDT. Well, that is one major side effect.

There is a degree of unionization. In every country that has it—Canada splits organized medicine into two parts, that part that deals with scientific, professional matters, and that part that deals with economic matters. And they are separate groups, although physicians belong to both.

Chairman HEINZ. Is the AMA a union?

Dr. REINHARDT. At the moment it has sometimes functioned as a quasi-union. At the moment, I would say actually no. They do not have the power over their members they once used to have. It is more a professional association now, although occasionally it makes gestures that remind one of a union.

Chairman HEINZ. There is one last question I cannot resist asking you, because it is quite an item of controversy up here on Capitol Hill, and that has to do with mandatory assignment.

There have been proposals—and I guess one of them is moving along over in the House of Representatives—that physicians' fees should be, for next year or 2 or 3, depending on which proposal you are looking at, frozen, and the physicians should be required to accept mandatory assignment, which is to say they cannot pass along to their patients any additional costs beyond the copayments and deductibles that are normally sanctioned.

What would be the effect of that kind of legislation?

A, would it control costs; B, how would it impact on the delivery of health care?

And with what kind of side effects, if any?

Dr. REINHARDT. Well, the first question, would it control costs, it would save some money. In the big sweep of things, it would not. Each time when you take 10 percent out of physicians' gross income, you are saving only 2 percentage points of national health expenditures. That is gross income. And that income is about 60 percent of that. So it is really only 1.2 percent.

There would be a whole lot of dollar mileage in controlling physicians' incomes that way. And that has to be recognized.

You might still——

Chairman HEINZ. And that could still be a lot of money.

We are talking about a $25 billion program. 1.2 percent of that per year, over 3 years, that is a billion dollars.

Dr. REINHARDT. Yes. It is half a space program. That is true.

Chairman HEINZ. A billion here, a billion there. I assume you are talking about not 9 zeroes, but 10 of them.

Dr. REINHARDT. This building reminds me of that payment. That is certainly true. But it would not be something that you can then go to the press and say, we have really solved this problem, although it could be a billion dollars. And these are really focused elsewhere.

If you have mandatory assignment, my sense would be that most physicians could not afford to lose that business. I have a table in here somewhere that shows the extent to which physicians now do rely on medicare, medicaid: Radiologists, 42 percent; plastic surgeons, 42 percent of their business is medicare/medicaid. If you made assignment mandatory, they could not afford to lose the business. Given that most of their costs are fixed, it would be profitable for them to continue to accept that business.

I think very few physicians would say, "I will not take the aged." They will testify to you that they will, but when the chips are down, they probably would not.

Now, some physicians would, in fact, not accept the aged anymore. And they would no longer be accessible.

Chairman HEINZ. Who would they most likely be?

Dr. REINHARDT. They would be physicians in very high priced areas, they're Beverly Hills, or areas possibly that are somewhat underdoctored.

Frankly, I doubt that it would be very many.

If you had to—if you told the physicians either you take our fees or you can't have any medicare business at all—this is how Quebec, for example, does its health insurance—I think 5 percent of the physicians at most drop out of the system, and practice totally private medicine.

Chairman HEINZ. Very well.

Senator Burdick, you have any additional questions?

Senator BURDICK. I was wondering: Have you enough experience to know how voluntary assignments are going?

Dr. REINHARDT. The voluntary assignments now, I think less than half the physicians take it. Research has shown that it depends very much on the tension that exists between the fees they would like to get and the fees that medicare allows. I think short of mandatory assignment, I am sure that the voluntary assignment system has been as efficiently run as it might be. I am not aware that there exists an 800 line that the agent can call to find out who in my area does take assignment, or that there are published lists with computers that—now, every child has a computer in our town. It should be feasible to make such information routinely available, as a first step.

Because, let's face it, mandatory assignment is in some sense a little un-American. We cannot probably agree to that. And one might try first to give transparency to that before going to a physician. The aged person would know, does that physician take assignments. It takes a certain courage to talk to the physician about fees.

I think we sometimes overlook that.

And it is better to spare the patient the embarrassment of asking the physician and just have it routinely available from a third source. So that would be phase 1, and see where that leads us.

Eventually, however, if you want medicare to be an insurance program that does protect the aged from unpredictable and high costs, you might have to go to mandatory. It seems to me that is also an un-American way. The business will do it, too. They will negotiate preferred providers and say, we pay so much, and no more, do you want our business?

We do that in the business world. It is not completely a conspiracy to have mandatory assignments.

You know, the Government has some right to say, "We are the purchaser, these are the fees we pay; would you like to do business with us?"

If not, enough people do business at those fees, that is a signal that you should raise them.

Senator BURDICK. I think we have to find some answer, because right now insurance only covers about half the costs. And some of these poor people cannot meet the other half. We have got a problem ahead of us.

Dr. REINHARDT. I think it is, in my professional view, I think it is scandalous.

Chairman HEINZ. Dr. Reinhardt, you have given us some very, very good ideas, and an excellent conceptual analysis.

Thank you very much for your time and your efforts that went into your testimony, and your excellent answers to the questions.

Thank you so much.

Dr. REINHARDT. Thank you for having me.

And I really enjoyed this questioning.

Thank you.

[The prepared statement of Dr. Reinhardt follows:]

18

A FRAMEWORK FOR DELIBERATIONS
ON
THE COMPENSATION OF PHYSICIANS

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Statement before the United States Senate Special Committee
on Aging; Hearing on Physician Reimbursement,
Washington, D.C.,
March 16, 1984

I

My name is Uwe E. Reinhardt. I am a Professor of Economics and Public Affairs at Princeton University, Princeton, New Jersey. Much of my research during the past decade has been devoted to health services research and the analysis of health policy.

I would like to thank you, Senator Heinz, and your colleagues for inviting me to comment on the issue of physician compensation. I have long had a professional, academic interest in that subject matter and am honored to share my thoughts on the issue with you and your colleagues.

Your Committee has available to it Lynn Etheredge's background paper "MEDICARE: PAYING THE PHYSICIAN." That truly excellent paper is so thorough in its sweep of pertinent data as to obviate the need for much further basic data. The mandate given to me by your staff has been to present, instead, a somewhat broader conceptual framework within which Mr. Etheredge's paper, and those of subsequent speakers at this Hearing, can be viewed. In the next section of this statement I shall try to provide such a framework. Thereafter, in Section III, I shall conclude with some thoughts on the policy options now before the Congress.

II

Both the medical profession and public policymakers have fallen into the habit of referring to the payment of physicians as "reimbursement." The term connotes mere restoration for expenses the physician had somehow incurred in rendering medical services. While a portion of the physician's payment does constitute _bona fide_ reimbursement in this sense, the bulk of that payment is simply a wage paid for the physician's skill and time, just as the bulk of a craftman's wage represents pay for his skill and time. The topic of "physician reimbursement," then, centers on two questions: (1) What is an appropriate wage for a physician, and (2) how should that wage be paid?

Presumably we would like to see the wage paid any person in our society to be both _fair_ and _efficient_. We tend to assess the _fairness_ of a compensation scheme by the payment the individual receives per hour of work. We can assess the _efficiency_ of a compensation scheme by the degree to which it maximizes the value of the services the individual renders society per dollar of compensation we pay him or her.

Even for professionals guided by a code of ethics the efficiency inherent in a compensation scheme is likely to depend on the _base_ on which the professional's compensation is calculated. For physicians, that _base_ may be the input of his or her time or, alternatively, the number of procedures performed, the number of medical cases treated or the number of patients under the physicians continuing care. The physicians behavior is apt to be sensitive to the particular _base_ on which he or she is paid.

In Section A below, I would like to comment upon standards of fairness in physician compensation. Thereafter, in Section B, I shall reflect on the base upon which compensation is paid.

A. Standards of Fairness For Physician Compensation

In 1982, national health care expenditures in the United States reached an estimated $322.4 billion, of which $61.8 billion -- or 19 percent -- represented the cost of all services and supplies provided in physicians' offices or by private practitioners in hospitals.[1] If the physicians' receipts are related strictly to expenditures for personal health care (a figure that excludes program administration, the net cost of insurance, research and construction of medical facilities) the physicians' share represents 21.5 percent of the total.

This proportion carries over into the Medicare program as well. In 1982, for example, Medicare spent $11.4 billion on physician services, which representes 21.8 percent of total Medicare expenditures of $52.2 billion. The comparable percentages for 1970 and 1975 were 21.3 and 20.2, respectively.

As a rule of thumb, then, it can be said that roughly one of every five health care dollars in the United States accrues to private medical practitioners. Thus, for every 10 percentage point reduction in expenditures on physician services we reduce total national health expenditures by only about 2 percentage points. That percentage is even smaller if we contemplate reductions in the physicians pretax net practice income.

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[1] Robert M. Gibson, Daniel R. Waldo and Katharine R. Levit, "National Health Expenditures, 1982," Health Care Financing Review, Fall, 1983 pp. 1-31.

How do total national expenditures on physician services translate themselves into physician income? According to the most recent estimates available, total national expenditures on physician services in 1982 represented an average gross practice income of $178,000 per physician, of which a reported average of $78,400 represented professional tax-deductible expenses and $99,500 the reported average pretax net income per physician.[2] Included in the expenses of $78,400 are some $12,000 of outlays on professional automobiles, professional development, contributions to tax-deferred compensation and similar expenditures that should really be viewed as income sheltered from taxation. As Lynn Etheredge shows in Table 16 of his paper, the average bona fide practice expenses total only about $66,400, including non-physician payroll ($30,400), other office expenses ($17,500), medical supplies ($7,800), medical liability insurance ($5,800) and medical equipment ($4,900).

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[2] American Medical Association, Socioeconomic Characteristics of Medical Practice 1983, Tables 33 and 38.

Bona fide practice expenses thus average about 37 percent of gross income, and net income about 63 percent.

The average income of $99,500 (or, really, of $111,000) masks considerable variation among physicians. Table 1, showing data for 1981 (rather than 1982), illustrate that variation. On average, orthopaedic surgeons and neurosurgeons netted about twice as much as general practitioners, family practitioners, pediatricians and psychiatrists. Overall, surgical specialists as a group earned about 42 percent more than all non-surgical specialists. Furthermore, as Table 1 shows, there is considerable variation in net income even within a given specialty. It is, thus, somewhat risky to generalize about physician incomes: there are physicians with truly high incomes and those with fairly modest ones.

In the well-known annual surveys conducted by the American Medical Association, physicians tend to report an average of about 47 weeks of practice per year. In 1982, they reported an overall average of 56.8 hours per week spent on all professional activities. Of this total, an average of 51 hours per week were reported to have been spent on "patient care activities." If one accepts these self-reported figures as an accurate measure of the physician's work-week and -year, and if one also accepts as accurate the reported income and expense figures, then the average gross compensation of physicians in 1982 (prior to deduction of practice costs) appears to have been roughly $75 per hour of patient care activity for all physicians. Table 2 below presents the comparable figures for selected specialties. These numbers are, of course, mere overall averages that are only as reliable as the self-reported numbers indicated by the physicians responding to the AMA survey. Furthermore, as noted, these averages mask considerable inter-physician variation even

TABLE 1

THE DISTRIBUTION OF PRETAX NET PRACTICE INCOME PER PHYSICIAN
UNITED STATES, 1981

NET PRACTICE INCOME PER PHYSICIAN	ALL SPECIALTIES	GENERAL PRACTITIONERS	ALL NON-SURGICAL SPECIALISTS	ORTHOPEDIC SURGEONS	ALL SURGICAL SPECIALISTS	RADIOLOGISTS
$ 200,000 or more	5 %	1 %	3 %	22 %	13 %	16 %
$ 150,000-199,999	7 %	2 %	4 %	14 %	11 %	17 %
$ 125,000-149,999	10 %	3 %	12 %	20 %	18 %	19 %
$ 100,000-124,999	16 %	10 %	16 %	19 %	19 %	25 %
$ 90,000 99,999	7 %	7 %	8 %	9 %	7 %	6 %
$ 80,000-89,999	9 %	11 %	11 %	3 %	7 %	4 %
$ 70,000-79,999	10 %	8 %	10 %	4 %	7 %	5 %
$ 60,000 69,000	11 %	13 %	11 %	2 %	6 %	3 %
$ 50,000-59,999	9 %	12 %	8 %	2 %	4 %	1 %
$ 49,000 or less	18 %	33 %	17 %	5 %	8 %	4 %
MEDIANS	$ 86,210	$ 63,950	$ 83,800	$ 134,670	$ 111,860	$ 127,310

Source: Adapted from Arthur Owens, "Do You Know Where You Fit In?" MEDICAL ECONOMICS, September 1982, pp.248 and pp. 252-3.

TABLE 2

REPORTED ANNUAL AND HOURLY COMPENSATION OF PHYSICIANS UNITED STATES, 1982[a]

SPECIALTY	AVERAGE GROSS INCOME		AVERAGE NET INCOME	
	PER YEAR	PER HOUR	PER YEAR	PER HOUR
	$	$/HR	$	$/HR
Pediatrics	137,000	57	70,300	29
General/Family Practice	147,600	59	71,900	29
Internal Medicine	162,000	66	86,800	35
Radiologists	204,900	81	136,800	54
Obstetrics/ Gynecology	224,800	89	115,800	46
Psychologists	190,200	94	76,500	38
Surgeons	235,000	97	130,500	54
Pathologists	196,300	102	114,400	59

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[a] For each specialty, the annual gross income is the sum of the average reported net practice income and the average reported tax-deductible professional expenses. The hourly figures were obtained by dividing the annual figures by 47 (weeks per year) and then by the reported average weekly hours "in patient care activities" for the specialty in question.

Source: Computed from American Medical Association, op. cit., Tables 4, 33, and 38.

within specialties. Finally, the net income figures in the table are somewhat understated, as they are net of expenditures on automobiles, professional development and tax-deferred compensation. As noted earlier, these tax-deductible expenses are often just a form of income.

How is one to react to the gross hourly rates reported in Table 2? Do they suggest that physicians are paid too much, too little or just about properly? To make such an assessment, one can employ two quite different standards, namely:

1. the standard of comparable worth, or
2. the standard of the market.

The Standard of Comparable Worth

Adherents to the standard of comparable worth believe that the appropriateness of an individual's compensation can be assessed by comparing the individual's hourly compensation to that of "similar" persons in different activities. It is a standard often proposed by womens' organizations and, not infrequently also, by medical practitioners in defense of their incomes.

The philosophy underlying this approach dates back to the medieval doctrine "just price," a doctrine apparently legitimized by St. Thomas Acquinas, but actually originating in the writings of Aristotle. It is a doctrine with seemingly eternal appeal.

In the modern application of this doctrine, one seeks to establish "similarity" of individuals in different occupations primarily by their levels of education and training. Thus, a registered nurse is said to be roughly comparable to a high-school teacher, a telephone operator to a service-station attendant, a physician to a lawyer, and so on.

How does the estimated average hourly gross income of physicians shown in Table 2 fare under the doctrine of comparable worth? The answer is: it depends where we look.

In applying the doctrine, physicians tend to compare themselves to business executives or corporate- and tax-lawyers. On that comparison they have reason to lament. Noting the extraordinarily high incomes of American business executives and the steep hourly billings of, say, the average Wall Street lawyer, the typical American physician must feel downright underpaid. He or she may feel doubly so in view of the fact that the high billings for the legal work in, say, a routine bond flotation represents -- let us be frank about it -- work that taxes neither intellect nor emotion. Physicians can also point out that much of the tax lawyers' work -- however ingenious it may be -- nevertheless represents but a zero- or negative sum game. Tax lawyers may enrich their client at some other taxpayer's expense, but it is rare that they make any net positive contribution to total social output. By comparison, the work of the typical medical practitioner usually _is_ intellectually challenging, it often _is_ emotionally taxing and, most important of all, it typically _does_ represent a decidedly valuable net contribution to social output. It is surely not difficult to develop some sympathy for the physician's position on this point.

Unfortunately, the doctrine of comparable worth conveys confusing signals if one targets it elsewhere. First, neither all business executives nor all lawyers earn high incomes. As was reported in the

Wall Street Journal only recently (March 13, 1984), the average net income of lawyers in this country is only about $49,500, a figure much below average physician compensation. Furthermore, it is difficult to justify with the doctrine the relatively low compensation of the nation's eminent scientists whose incomes also tend to be much below that of physicians. In the end, then, the doctrine of comparable worth inevitably leads one into a morass of conflicting claims and counterclaims that remain entirely subjective. The standard does not recommend itself to either the policymaker or to the medical profession itself. A more objective and also probably fairer standard can be found in the market place.

The Standard of Supply and Demand

Under the standard of the market, a profession's level of compensation is defined as adequate if it elicits the supply of professionals society desires. If the prevailing income of, say, nurses is such as to engender a shortage of nurses in hospitals, then the level of nurse compensation is *ipso facto* inadequate. Similarly, if at prevailing levels of physician income in a given geographic area there were a shortage of physicians, then that level of compensation must be judged inadequate.

On this standard, the prevailing level of physician compensation for the United States as a whole cannot be judged inadequate. On the contrary, it is more likely to be judged excessive. For, in spite of the ever-increasing cost of tuition charged by medical schools, the number of qualified applicants to American medical schools still exceeds the available places by a substantial margin. At the same time, there is near-universal agreement that, even at given, constrained levels of medical school capacity, the prospective supply of physicians in this country will be more than adequate -- that it may well be excessive. Within the context of a market economy, these circumstances suggest that tuition charges at American medical schools are still too low and/or that physician incomes are too high -- that is, that physician incomes are higher than they need be to assure this nation of an adequate future supply of physicians.

American physicians may find it hard to accept this crass verdict. As noted, in connection with their own incomes they typically prefer a judiciously selective application of the doctrine of comparable worth. That standard, however, ought not to have a place in a profession which has traditionally declared itself a staunch ally of free-market principles. The doctrine of "just price" and its modern descendent, the doctrine of comparable worth, is just not consistent with a free-market philosophy.

B. Alternative Bases for Physician Compensation

In any production process, one may compensate individuals participating in it on two distinct, alternative bases, namely:

1. the contribution the individual makes to the value of total output; or
2. the time the individual is observed or reported to have contributed to the production process in question.

In the context of a market economy, it is generally considered not only efficient but also fair to link the individual's compensation as closely as possible to the value he or she contributes through his participation in production. That penchant argues for the first of these two bases. As it happens, however, the second base is by far the more widely applied throughout the economy, presumably because it is typically just not feasible, technically, to isolate an individual's contribution to the total value of the output produced. For the most part, therefore, recourse is had to compensation per hour, per week, or per month, that is, to compensation per unit time of input into the production process.

Medical care furnishes one notable exception to this pattern. In that field we find both output- and input-related compensation bases, to wit:

Output-related Compensation

a) compensation based on procedures rendered (fee-for-service compensation).

b) compensation by medical case (e.g., the currently proposed compensation by Diagnostic Related Group (DRG)).

c) payment for the number of patients treated per quarter or per year (capitation).

Input-related Compensation

d) compensation by the hour (e.g., in moonlighting by residents).

e) salaried practice.

The choice of one or the other of these compensatin bases is, in the first place, dictated strictly by the *technical* feasibility of the base. If one desires physicians to cooperate freely in the treatment of a patient -- for example in a teaching hospital -- then it is often just more convenient and pedagogically sound not to keep track of each practitioner's contribution to the treatment, but instead to compensate all participating physicians by salary. Similarly, it is typically not feasible to compensate by capitation a specialist who performs only a select number of tasks in the management of particular patients. Finally, compensation by medical case (by DRG) makes little sense when distinct cases cannot be accurately identified, as may well be the case when older patients present with complex multiple diagnoses.

Thus, before even thinking about the relative economic merits of alternative compensation bases, one would want to be sure that a proposed compensation base is technically feasible in the first place. It is an obvious point that is sometimes overlooked in debates on physician compensation.

In a good number of situations, several alternative bases may, of course, be technically feasible. In such cases, one's choice must then be guided by at least two factors:

a) the likely effect of the compensation base on the *clinical quality* and the amenities of the physicians practice; and

b) the likely effect on the *cost* of the physician's treatments.

Unfortunately, each of the compensation bases listed above tends to have both desirable and undesirable effects on the cost and quality of medical care. It does not seem possible in the abstract to declare one base as unequivocally superior to the other.

Where such declarations are nevertheless given, they must either apply to concrete situations in which the likely effects on cost and quality are known empirically or, just as probably, these declarations simply reflect their author's beliefs and ideological predilections.

Table 3 overleaf presents a synopsis of the pros and cons of alternative compensation bases. As must be any such table, Table 3 is inevitably somewhat superficial. It is presented here simply to highlight the complexity of choosing a base for physician compensation.

Fee-For-Service Compensation

The application of fee-for-service compensation proceeds on the tacit assumption that it is technically meaningful to decompose the physician's contribution to the management of a patient's medical condition into a series of discrete tasks that can be individuallly priced. The method is widely used, not only in the United States, but also under the national health insurance systems of Canada, France and West Germany.

Critics of the method are skeptical that a sensible decomposition of the physician's workday is, in fact, feasible or even desirable. They worry about the behavioral implications of the method. Because the method does reward the physician explicitly for every procedure applied

TABLE 3

STRENGTHS AND WEAKNESSES OF ALTERNATIVE BASES FOR PHYSICIAN COMPENSATION

BASE	ADVANTAGES	DISADVANTAGES
A. INDIVIDUAL PROCEDURE (Fee-for-Service)	o Automatic adjustment for case complexity o Provider's reward is closely linked to his/her output of services o Patients have economic clout over physician o Provides transparency of the physician's profile of practice o Widely used throughout the world and typically preferred by physicians	o Provides incentive for over-servicing per case treated o If fees for particular services do not stand in constant proportion to the cost of these services, fee-for-service compensation may tilt the treatment modality towards more profitable procedures o Inflationary tendency through ever finer decomposition of treatments into distinct, billable tasks. o Difficult to budget ex ante
B. THE MEDICAL CASE (Diagnostic Related Groups)	o Logically the most compelling definition of the physician's "output" o Fairly good adjustment for variation in case mix (albeit not a perfect adjustment) o Provider's reward is fairly closely linked to his/her output of services o Provider has economic incentive to minimize the resource cost per medical case treated o Patients retain economic clout over physicians o Fairly good transparency of the physician's practice profile.	o It is technically difficult to force all cases into a finite list of DRG's o There may be substantial variation of case complexity within a defined case category (DRG) o To the extent that case complexity varies significantly within DRGs, physicians may engage in adverse risk selection of patients o Physicians may underservice their patients for the sake of economic gain o Physicians may misrepresent diagnoses (DRG creep) o The method is relatively untried here or elsewhere in the world. o Difficult to budget ex ante

TABLE 3
(continued)

BASE	ADVANTAGES	DISADVANTAGES
C. NUMBER OF PATIENTS UNDER CONTINUING CARE (capitation)	o No need to decompose physician's work into procedures or cases; therefore, administratively simple o Facilitates budgeting for health care ex ante o Provider's effort still somewhat linked to his or her effort o Medical treatments are not influenced by the relative profitability of individual procedures o Physicians have incentive to minimize the cost of medical treatments o Patients still have some economic clout over physicians if patients can switch physicians from time to time	o Physicians have incentive for adverse risk selection and may dump patients with complex, costly conditions onto other providers o Physicians have incentive to underserve patients they do accept (to the extent that patients remain unaware of it) o If average case mix varies greatly among physicians under one capitation system, capitation may be viewed as unfair. o There is little transparency of the physician's practice profile.
D. MONTH OR YEAR (salaried practice)	o Administratively simple o Medical treatments are not influenced by the relative profitability of individual procedures o Facilitates cooperation among physicians in treating complex cases o Facilitates budgeting for health care expenditures ex ante	o Unless salary can be linked somehow to output and patient satisfaction (as it is in group practices), patients lose economic clout over the physician who renders care as an act of noblesse oblige. o Physicians may underserve patients o There is little transparency of the physician's practice profile.

to the management of a medical condition, it can be expected to lead to highly resource-intensive treatments, especially when the patient is fairly well insured and physicians are in excess supply. The smallest base on which such critics would like to see compensation based would be the medical case, as is now being proposed by the advocates of DRG compensation.

Compensation by Case

In the abstract, compensation by distinct medical case has desirable behavioral implications. In theory, at least, the physician has every incentive to minimize the resource-intensity of medical treatment. Indeed, (s)he has the incentive literally to skimp on resources. The latter incentive, however, can be expected to be mitigated by the patient's own evaluation of the quality of care, once again, at least in theory. In practice, of course, patients may not even know or discover too late when they have been medically ill served.

Unfortunately, it is not clear just how far one can go in decomposing the physician's workday into distinct medical cases. First, many patients -- especially the aged -- present with multiple diagnoses. They represent several medical cases wrapped into one episode of illness. Second, numerous medical cases are not finite. They involve chronic conditions. Third, many physicians -- particularly medical specialists -- treat not entire cases but merely certain specialized aspects of cases. Such physicians need to be compensated for their distinct contribution to the overall management of a case. It is not clear how this can be accomplished within compensation by case, unless the entire delivery system can be switched to a so-called primary-care network in which some primary-care physician is compensated by case and required to compensate specialists out of the case payment. Such a wholesale change, however, would be truly revolutionary at this time.

Finally, one should not overlook one particularly bothersome behavioral implication of compensation by case. As is likely to be shown later on in this Hearing, the resource costs per identifiable medical case exhibit considerable dispersion among cases. There are, for every distinct DRG, low-cost and high-cost cases. If compensation by case implies a given, preset fee for all such cases in a DRG, the the physician has an economic incentive to accept for treatment only those cases that seem, ex ante, low cost. It would be difficult in practice to prohibit such adverse risk selection through regulation.

Capitation

In a sense, one may view capitation as an attempt to approximate compensation by medical case. Instead of identifying distinct medical cases, however, one proceeds on the hypothesis that, over a sufficiently long period of time (e.g., a quarter or full year) high-cost and low-cost cases will balance one another, and that it is therefore meaningful to think of an imaginary "typical" or "average" case with the duration of, say, a quarter or a year.

This approach makes sense when the individual physician's average case load over such periods is, indeed, more or less similar to the overall average case mix in a wider reference group -- e.g., the case load of all physicians in a region or even in the entire nation. Where this condition is not met, the capitation method must be redefined to account for inter-physician differences in the complexity of case load. If that refinement is not feasible, use of the capitation method is likely to lead to tension among physicians. It is also likely to trigger shifting of unusually sick patients to other physicians or facilities. There is the added problem that, for specialists treating only one particular aspect of a given episode of illness, compensation by capitation makes no more sense than compensation by case. One must switch to compensation per procedure or per hour of the specialist's time.

Capitation is used for general practitioners in England and in Holland. It is also occasionally used in the United States. It is remarkable, however, that even in England, where capitation has long been the rule for self-employed general practitioners, the latter receive only about half of their income strictly in the form of capitation. The remainder comes in the form of separate payments for distinct services (e.g., preventive care) or through subsidies of various forms. In the United States, capitation is found chiefly in the context of prepaid group practice in which the group as a whole acts as the entry point of a primary-care network.

Compensation by capitation will undoubtedly always represent one of many methods of paying physicians in this country. Its widespread application to the Medicare/Medicaid programs, however, once again presupposes the wholesale conversion of these programs into primary-care networks. That may be neither technically nor politically feasible in the short run.

Salary

Compensation by salary is indicated when it is not meaningful to decompose the physician's professional activity into identifiable procedures, cases or patient counts. One typically finds it where patient care and other activities (e.g., teaching or research) are inextricably intermingled, or where it is desired that several physicians cooperate freely in the treatment of patients -- for example, in multispecialty groups or clinics. Indeed, one of the plusses often claimed for salaried medical practice is that it facilitates such cooperation.

Advocates of salaried medical practice frequently argue that this form of compensation "takes money out of medicine" and thus restores medicine to a truly professional basis. That view can be questioned. Salaried practice does not take money out of medicine; it merely puts it in another way. The question is whether it does so usefully.

It is self-evident that salaried medical practice removes any direct pecuniary incentive to over-prescribe medical services per episode of illness. Whether it removes all indirect incentives, however, is not clear. It must surely depend on the link that is established between the physician's salary and his or her economic contribution to the organization paying the salary. For example, if a salaried physician is a member of a group practice which itself is paid on a fee-for-service basis, then the group is apt to develop a linkage between the physician's salary and his or her contribution to gross revenues. For example, there may be pressure on the physician to apply an underused X-ray machine or laboratory and he or she may be rewarded with additional salary for doing so. In thinking about salaried medical practice, therefore, one must keep in mind the institutional setting surrounding the salaried physician. If that setting is a fee-for-service group practice, many of the incentives inherent in fee-for-service compensation are likely to be transferred to the ostensibly salaried physician as well. (S)he will behave as if (s)he were paid fee-for-service.

In this connection it is well to keep in mind also that salaried practice in a medical group is likely to be only a transitory phase in a young physician's career. Salaried practice in a group is a mutually beneficial arrangement for both the older group members and the recent medical graduate. In return for giving up some of the profit contributed by him or her, the recent medical graduate is offered an income floor, that is, a reduction of risk. In return for bearing that risk, the older members can, in effect, enjoy the benefits of a form of fee splitting without having it appear as such. (Indeed, an income-sharing group practice can be viewed as a vehicle for fee-splitting not only among young and older physicians, but also among equally aged physicians in different specialties. The surgeons in a group, for example, may find it in their interest to distribute to pediatricians more than the latters' own gross billing if pediatricians act as a conduit for surgical cases.)

Even if the salaried physician's own salary were completely insensitive to the volume and mix of services (s)he prescribes, however, it is not clear that the patient's welfare is necessarily enhanced by "taking money out of medicine" in this way. Unless there exists a mechanism for tying the physician's salary directly to the satisfaction of patients treated by him or her, patients may in fact be reduced to receive the physician's care as an act of noblesse oblige. Such a system can rob the patient of the economic clout any client should have over the provider of professional services. It is a major drawback of salaried professional practice -- and one, incidentally, which the nation's college students constantly deplore in the context of salaried pedagogic practice (higher education), sometimes with good cause.

To sum up at this point: Although one sometimes finds strong arguments in favor of this or that compensation base for medical practice, there does not in fact exist a single base that is clearly superior in all contexts. First, not every base is technically feasible. To attempt the technically infeasible in health policy is not unheard of but it is clearly to invite disaster. Furthermore, every technically feasible compensation base brings with it conflicting economic incentives, some working to the patient's medical and/or economic advantage, and others to the patient's disadvantage. To declare one or the other base as theoretically superior is nothing more than to (a) impose one's own value judgements on the pros and cons and (b) to market one's own set of hypotheses about the relative strength of conflicting incentives. The matter is, unfortunately, as murkey and as complicated as that.

III

REFLECTIONS ON POLICY OPTIONS BEFORE CONGRESS

As is shown in Lynn Etheredge's background paper for this Hearing, American physicians are paid on a great variety of bases among which salaried practice appears to be growing. According to his Table 23, about 23 percent of all professionally active physicians are now (presumably salaried) employees and only 77 percent are self-employed. Of the latter, about half are in group medical practices, often on a full or partially salaried basis.

Lest we think that there is a rapid, wholesale shift of American medicine toward salaried practice, however, it is well not to confuse the fiscal nexus between patients and the medical practice with the fiscal nexus between the medical practice and the individual physician working within it. At this time, the predominant form of the fiscal nexus between patients (and third parties) on the one hand and the medical practice on the other is fee-for-service compensation. That method has long been favored by American physicians and, incidentally, by physicians elsewhere as well.

It would be my sense that any workable reform of physician reimbursement in this country must be structured around the preservation of the fee-for-service principle. If there have been shortcomings in that system -- especially as it has been applied by Medicare -- they probably reside less in the method per se than in the peculiar way we have used it in this country.

What distinguishes fee-for-service in the United States from it foreign cousins is the freedom granted the individual physician to set the fee for the individual procedure on a patient by patient basis. With few exceptions, that freedom is absolute. Most societies would not even dream of granting their physicians quite so much freedom to price their own services -- a freedom taken for granted by American physicians. There are two reasons for the more stringent attitude elsewhere, reasons that actually apply in the United States as well.

First, the bulk of physician services in these countries are covered by third-party payment. Under such a system it usually does not make sense to let the individual practitioner set his/her own fees -- fees the patient does not directly pay or even perceive. Resort is had instead to binding, predetermined fee schedules negotiated with physicians collectively. This is the approach in Canada, in France and in West Germany.

A second reason for curbing the individual physician's freedom to price resides in the monopoly the state bestowes upon the medical profession through the mechanism of professional licensure. The ostensible objective of professional licensure is to protect patients from their own ignorance in medical matters. In fact, however, this grant of power also represents government-supplied protection of economic turf, a protection highly coveted and jealously guarded by the medical profession. Physicians in other countries have long realized that, by asking the state for such protection, a profession inevitably also invites the state into its practice. After all, a government would be derelict in its duties if, after granting a profession a monopoly over certain economic activities, it did not supervise closely just how that monopoly is exercised by that profession. The government's legitimate interest in physician fees rests on the economic protection physicians continue to seek from the government.[3]

A. Reform of Fee-For-Service Payment Under Medicare

As is shown in the most recent issue of the Health Care Financing Review (Fall, 1983), roughly two-thirds of total gross physician compensation in the United States is now covered by third parties. Of this coverage, 35.2 percentage points represent private health insurance; the remaining 27.6 percentage points come from public sources. These figures cover both ambulatory and inpatient physician services. For the latter, insurance coverage is considerably higher than 62 percent.

These figures are roughly consistent with a recent MEDICAL ECONOMICS survey of third-party payment.[4] Table 4 below presents excerpts from this survey. It is seen that Medicare/Medicaid are reported to account for 25 percent of the respondents' gross income. This percentage varies substantially by specialty, reaching as much as an average of 42 percent for thoracic surgeons. Table 4 also shows that the percentage

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[3] Incidentally, such supervision is not required in the (unlicensed) field of economics where even former divinity students may blatantly practice economics.

[4] See Arthur Owens "How Much Money Comes from Third Parties?" MEDICAL ECONOMICS, April 4, 1983; pp. 254-63.

TABLE 4

PHYSICIANS' GROSS INCOME BY SOURCE
UNITED STATES, 1981

	PERCENTAGE PAID BY NAMED THIRD PARTY				
	Commercial health plans	Blue Shield	Medicare	Medicaid	Fees Paid By Pats.
Anesthesiologists	27 %	29 %	22 %	10 %	9 %
FPs	17	13	15	9	42
GPs	17	13	18	10	38
General surgeons	26	27	25	8	11
Internists	15	19	29	7	27
Neurologists	22	22	24	9	16
Neurosurgeons	32	28	18	8	8
OBGs	32	30	5	8	21
Ophthalmologists	10	11	24	8	44
Orthopedic surgeons	31	25	17	6	13
Pathologists	14	26	21	11	9
Pediatricians	14	12	1	9	57
Plastic surgeons	25	22	12	5	21
Psychiatrists	24	19	6	5	40
Radiologists	18	28	28	11	12
Thoracic surgeons	21	26	35	7	8
All surgical specialists	26	25	20	8	16
All non-surgical specialists	19	20	17	8	29
All M.D.s	21	20	17	8	29

Source: Adapted from Arthur Owens, "How Much of Your Money Comes from Third Parties?" MEDICAL ECONOMICS, April 4, 1983, pp. 258 and 262.

of physician income paid directly by patients varies substantially by specialty. Finally, Table 5 suggests a clear positive correlation between physicians' gross billing and the percentage of their income derived from third parties.

Foreign observers frequently wonder how the American physician's total freedom to set his fees could have been preserved in the face of so much third-party coverage. The secret lies in the uniquely American system of "usual, customary and reasonable" (UCR) fees. The particular operation of that system varies somewhat among insurance carriers, but the basic idea is this: the individual physician is free to set fees as he or she sees fit, and the insurance carrier pays it as long as the fee is the physician's "customary" fee for the service and the fee is "reasonable" by not exceeding the fee of, say, the 10 percent most expensive physicians in his or her market area.[5] And, should the insurance carrier decline to pay the billed fee in full, the physician is free to recover the balance from the patient.

The UCR system has generated a system of fees that would be difficult to defend with appeals to reason. There are large and seemingly capricious differences among physicians in fees for given procedures, as can be seen in Table 27 of Lynn Etheredge's paper (a table reproduced overleaf). While the UCR system used by Medicare has sought to limit the inherently inflationary tendency of the UCR mechanism by putting limits on the allowed annual increases in the

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[5] The UCR system is well described in Lynn Etheredge's paper.

TABLE 5

PHYSICIAN INCOME BY THIRD-PARTY COVERAGE

UNITED STATES, 1981

GROSS INCOME PER PHYSICIAN	PERCENTAGE OF INCOME FROM FEES PAID DIRECTLY BY PATS.
Less than $60,000	39 %
$ 60,000 - $ 79,999	29
$ 80,000 - $139,999	32
$140,000 - $159,999	30
$160,000 - $179,999	25
$180,000 or more	23

SOURCE: Adapted from Arthur Owen, *Ibid.*, pp. 260-61.

TABLE 27
HIGH AND LOW PREVAILING MEDICARE CHARGES

Procedure/Fee Screen Year	High	Low	Ratio
1. Brief follow-up visit by an internist			
1976	$18.18	$6.70	2.71:1
1980	33.10	7.00	4.73:1
2. Extraction of lens by an opthalmologist			
1976	900.00	412.56	2.18:1
1980	1,390.70	536.50	2.59:1
3. Electrosection of prostate by a urologist			
1976	862.70	356.46	2.42:1
1980	1,410.40	475.25	2.97:1
4. Hysterectomy by an obstetrician/gynecologist			
1976	850.00	450.00	2.13:1
1980	1,305.20	536.50	2.43:1
5. Chest x-ray single view by a radiologist			
1976	25.00	4.00	6.25:1
1980	35.00	5.50	6.36:1

Source: HCFA "Medicare Part B Charges, Overview and Trends, Fee Screen Years, 1976-980, Feb. 3, 1982 p 44-48.

Cited in Lynn Etheredge, "MEDICARE: PAYING THE PHYSICIAN, History, Issues and Options," Mimeographed, March, 1983.

"reasonable" cutoff fees, the inequities implicit in the system persist and have virtually been frozen into the currently prevailing allowable Medicare fees. It was probably inevitable that the system would eventually invite proposals for a substantial overhaul.

One approach might be simply to abandon fee-for-service compensation (and with it the UCR system) altogether -- at least for Medicare -- and to switch to a radically different system -- for example, compensation by case or capitation. For reasons already hinted at in Section III and explicated once more further on, I would not recommend so drastic a change at this time. A more feasible approach might be simply to move the Medicare compensation system gradually to a fee-for-service system based on fee schedules negotiated between the government and appropriate associations of physicians. Ultimately, these fee schedules should:

1. observe equity among physicians in a given market area;
2. observe a close relationship between the fees for individual procedures and their time - and other costs; and
3. be high enough but not higher in absolute terms to attract an adequate number of physicians into each market area.

The present UCR system -- even as modified by Medicare -- falls egregiously short of these quite sensible desiderata.

How had the Medicare program best move towards such an improved system? Certainly not by any sudden change in policy which would drastically redistribute income among physicians. Instead, one might simply declare a general freeze on currently prevailing Medicare fees and, over time, relax that constraint selectively to shift the system gradually towards meeting the desiderata shown above. Thus, one might keep the freeze in place for some time in relatively overdoctored areas in which prevailing fees are already high (or for specialties whose Medicare fees now imply a relatively high remuneration per hour of work) letting fees drift up slowly everywhere else. Eventually there would emerge a more sensible, cost-based schedule of Medicare fees, one that implies greater equity in terms of fees earned by physicians in a given specialty per hour worked.

Just how swiftly and how far Medicare should move in the desired direction might be a matter for negotiation with the medical professions. One desirable by-product of such a negotiating session would be to force physicians now earning high Medicare fees (e.g., in New York) to show cause why they should be paid so much more than relatively less well-paid physicians (e.g., in Pennsylvania) for comparable procedures (e.g., hysterectomies or cataract extractions). An intraprofessional justification of the prevailing differentials is long overdue.

It may be asked whether the Medicare program possesses the economic clout to force such a change onto the medical market place. One should think that it does. As was shown in Table 4 above, for some specialties Medicare represents a major source of income. It is well known that for some procedures -- e.g., cataract extraction -- Medicare pays for the bulk of all such procedures performed in the United States. Physicians would surely think twice before losing that "business."

How successfully the Medicare program flexes its muscle depends in good part on its policy on "assignments." The most powerful tool in this respect would be mandatory assignment. In essence, Medicare would tell the physician that, to do "business" with Medicare at all, (s)he must accept the prevailing Medicare fee as payment in full for every Medicare patient treated by him or her.[1]

Short of moving to complete mandatory assignment, Medicare could probably tilt even the present voluntary assignment system more in the government's and the aged's favor. Current technology would surely permit the establishment of a toll-free line on which Medicare enrollees could readily receive information on the set of physicians in their market area who do accept assignment. Medicare might even publish and periodically update printed lists of such physicians and then let the market do its work.[2]

B. Other Reforms of Physician Compensation Under Medicare

There has been of recent some interest among policymakers in a shift away from fee-for-service compensation altogether and towards compensation by medical case -- by Diagnostic Related Groups. I am skeptical that such a shift is desirable or even feasible.

In principle, it would be ideal if for every conceivable medical condition one could turn to a primary-care physician as one would turn to a building contractor and request a bid for the total cost of managing the condition, including the cost of inpatient care. Upon paying the physician the estimated cost one would then leave it up to him or her to put together and pay for the treatment package, just as a building contractor configures and subcontracts for the building of a house. One wonders how many Americans would favor being the patient under this set of incentives. One wonders also whether such an approach is technically feasible in the first place.

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[1] The aged might, as they do now, bear some coinsurance.

[2] Obviously, well to do patients would enjoy a wider choice of physicians than would low-income patients, as is the case now.

A more sensible approach might be to split the total cost of a DRG into the physician's part and the hospital's part, and then paying each separately. Even that approach, however, has both technical and economic shortcomings.

As noted earlier, it may not be feasible, technically, to decompose the physician's work into neat sets of distinct cases (each with an appropriately low intra-case variability of complexity and cost). This decomposition may be especially difficult for old patients with multiple diagnoses.

There is the added problem that here, too, physicians have the incentive to underserve and/or to bump high risk (-cost) patients elsewhere. One must wonder why policymakers seem untroubled by this prospect, and how many tax dollars they actually expect to save by burdening aged patients with these risks -- let alone the political cost of forcing such a change down the throat of physicians.

Presumably, the current flirtation with DRG compensation by politicians arises out of concern over the incentive to overprescribe under fee-for-service compensation. Other nations have sought to curb this incentive by constructing quarterly practice profiles on individual physicians and by curbing the excesses of the outliers. American business is moving in the very same direction. Surely that form of monitoring -- so well tried elsewhere -- would be incorporated into the Medicare program as well.

In short, then, I would have to be much enlightened and strongly persuaded to see virtue in a wholesale shift toward physician compensation by DRG. I recommend instead the development of a more sensible fee-for-service system, based on negotiated fees and backed up with mandatory "assignment", if need be.

If DRG compensation must be tried one might start, perhaps, with specialties that enjoy a special franchise in inpatient care: radiologists, anesthesiologists and pathologists. Thus, one might seek to estimate the contribution these specialists make in the treatment of a Part A DRG, pay the hospital a reasonable amount to cover such services, and let the hospital subcontract competitively with such specialists for the performance of these services. The conversion of these specialists' franchise into a truly price-competitive market would be likely to reduce these physicians' gross- and net income. The savings in the aggregate would, of course, be rather modest. In the world of Washington, D.C., they might not be worth their political cost.

IV

CONCLUDING REMARKS

In conclusion, it may be well to call to mind once more that physicians have traditionally received only every fifth health care dollar spent by this nation. This relatively low percentage suggests that the nation can afford to pay its physicians well as long as it does so wisely.

It would neither by easy nor sensible to salvage the Medicare Trust Fund out of the bank accounts of the nation's medical practitioners. That should not even be the objective of "reimbursement reform." The objective of such a reform should be the development of a system that makes medical and economic sense, is equitable among physicians and does not further jeopardize the increasingly frail relationship between patient and physician. Other nations have done so with negotiated fee-schedules and with monitoring of utilization through statistical physician profiles. Over time, we should be able to develop that capacity as well.

Chairman Heinz. The next panel is made up of Vita Ostrander, William R. Hutton, Dr. James S. Todd, and Prof. Thomas H. Rice.

Ms. Ostrander and gentlemen, would you please come forward.

It is a traditional pleasure to welcome our first two visitors, Vita Ostrander, and then Bill Hutton, who represent the two largest associations of senior citizens and retired persons in the United States, AARP for Ms. Ostrander, and the National Council of Senior Citizens, in the case of Bill Hutton.

We are deeply grateful, Vita, to you, and may I say the same thing for Bill, for your continual willingness to come before our committee and enlighten us.

So, with your kindness in being here, once again, let me ask you to please proceed.

STATEMENT OF VITA OSTRANDER, WASHINGTON, D.C., PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS; ACCOMPANIED BY JACK CHRISTI, FEDERAL LEGISLATIVE STAFF, AARP

Ms. Ostrander. Thank you, Senator Heinz.

I am most appreciative of having the opportunity to be before this committee again today. I believe that the issue that we are beginning to debate is an issue that must be debated at this point.

With me is Jack Christi from our Federal legislative staff, who is a specialist in the health area. We have brought with us some charts to demonstrate visually what we will be explaining.

Although public and congressional attention has focused primarily on the crisis in part A trust fund, part B expenditures are rising faster. Part B expenditures are projected to increase 57 percent by 1985.

And I would like to have you look at a chart which demonstrates it very vividly. This will require a 17-percent-per-year increase in general revenue contribution to part B. And we must recognize that will continue to add to the deficit as well.

The primary cause of this escalation is the rising cost of physicians' services. In 1983, prices for physicians' services rose 7.7 percent, a rate 2½ times faster than the general prices in the economy.

The second chart, despite the rapid escalation in medicare, part B expenditures, medicare beneficiaries are required to pay over 60 percent of the cost of physician care out of pocket. Under existing law, medicare beneficiaries have substantial responsibility for the cost of physician services. Beneficiaries must pay the annual part B deductible of $75 plus 20 percent coinsurance on all reasonable, customary, and prevailing physicians' charges.

Beneficiaries are also liable for all charge reductions associated with unassigned physician claims.

And I think you heard some of the percentages on that.

These three charge components, charge reductions associated with unassigned claims, deductible in coinsurance, together represent variable beneficiary liability for physician services.

In 1983, such variable liability for the aged amounted to over 40 percent, really actually 40.5 percent of the physician charges due.

Further, if part B payments representing a form of fixed beneficiary liability are combined with variable beneficiary liability for 1983, then that medicare contribution against total physicians' charges falls to roughly 40 percent or 39.5 percent, the aged beneficiary being responsible for the remaining 60 percent of charges due to physicians.

Congress and others have been considering several proposals to restructure part B of medicare with a view toward limiting reimbursements to physicians. While there are strong equity arguments upon which to base such changes in part B, most of the currently debated proposals for restructuring part B would result in greater beneficiary costs, not a reduction in physicians' fees.

We are not dealing with the real problem. Freezing physicians' fees, unless the physician agrees to accept assignment on all claims, will significantly widen even the gap between medicare allowable charges and physicians' actual charges. The likely result is a dramatic drop in an already low assignment acceptance rate, and higher beneficiary out-of-pocket costs for physician care.

Moreover, plans simply calling for participating physician agreements offer no assurance against a decline in the overall medicare assignment rate. Physicians, like hospitals, must begin to share more of financial risk created by modern high technology medicine. No amount of marginal reform can change the basic inflationary incentives inherent in the cost plus and fee for service reimbursement system.

In the short term, AARP favors requiring hospitals to make their affiliated physicians accept assignment as a condition of the hospitals' participation in medicare. This proposal substantially reduces the physicians' ability to shift costs and provides adequate assurance that the beneficiaries will maintain access to care.

Over the long term, AARP favors a prospective payment system for physicians services. In addition, policymakers must begin to address the gap in compensation for technological procedures over cognitive services. I believe our previous speaker touched on that issue. Such subtle, but powerful, incentives must be corrected if we are to maintain affordable and accessible health care services for all Americans.

Thank you.

Chairman Heinz. Vita, thank you very much.

[The prepared statement of Ms. Ostrander follows:]

PREPARED STATEMENT OF VITA OSTRANDER

INTRODUCTION

Thank you, Mr. Chairman, for allowing me, on behalf of the 15.7 million members of the American Association of Retired Persons, (AARP), to state for this Committee AARP's deep concerns about Medicare's Supplementary Medical Insurance program, Medicare, Part B. My name is Vita Ostrander and I am the President-elect of AARP. AARP is concerned about Medicare's Part B program because, like the Part A trust fund, the Part B fund is heading for disaster. Though the general revenues financing three-fourths of Part B costs insure the program from bankruptcy, concern arises over this part of Medicare because the projected growth of SMI is so much higher than the growth in general revenues. The Congressional Budget Office projects that general revenue contributions to SMI must increase about 17 percent per year to finance the growth in the Part B program.

AARP is deeply concerned by the prospect of the Part B program requiring ever increasing shares of total general revenues to finance it. And despite the increase in general revenue contributions to Part B, the elderly are required to pay an ever increasing share of their income out-of-pocket for physician care. The time is long over due for Congress to address the thorny issues raised by the continually escalating cost of physician care.

AARP commends this Committee's leadership in tackling these tough issues. We welcome this opportunity to discuss the Part B program and to consider the incentives influencing physicians' decisions and driving up health care costs.

The Association's testimony today will consider three principal issue areas. They are:

1) The high out-of-pocket costs the elderly must pay for health care, particularly the out-of-pocket costs associated with physician care expenditures;
2) A brief review of the current proposals to restructure Part B; and
3) The development of a more stable and effective system of incentives for payment of physician services.

THE ELDERLY ARE THE MOST COST CONSCIOUS HEALTH CARE CONSUMERS IN THIS COUNTRY.

Most of the trendy proposals to reduce spending in Medicare are based on the notion that the elderly are not health cost conscious -- that they are somehow insulated by Medicare from the "true" cost of health care. Because of this insulation, so the theory goes, the elderly misuse or overuse the system and thereby increase Medicare costs. AARP rejects that theory.

The elderly are the most cost conscious health care consumers in this country. They have to be. Although they represent less than 12 percent of the population, the elderly account for 31 percent of all expenditures for hospital services, 28 percent of expenditures for physician services, 24 percent of prescription drug expenditures and 80 percent of all nursing home expenditures. Since Medicare pays for less than half of the elderly's health care expenses (about 45 percent), the elderly are painfully aware of the cost of paying for their own health care needs out-of-pocket. Moreover, AARP is not aware of any evidence to indicate that the elderly abuse or misuse the system. The escalating cost of Medicare is a function of uncontrolled health sector inflation, particularly hospital cost inflation and physician fee inflation, not beneficiary use of the system. Measured against the elderly's limited, fixed incomes and their huge out-of-pocket expenditures for health care, proposals for greater beneficiary cost sharing can only be characterized as punitive. To understand the magnitude of the impact that greater cost sharing proposals have on the elderly, a perspective on the scope of beneficiary out-of-pocket costs is in order.

BENEFICIARY OUT-OF-POCKET COSTS

Personal liability for the cost of health care provided to the elderly derives from a number of sources, all of which have been subject to significant increases over the past several years. The elderly pay directly for the following:

1. Deductibles under Parts A & B :

   The Part A deductible has increased from $104.00 in 1976 to $356.00 in 1984, an increase of 242 percent over the past 8 years. The annual Part B deductible has increased from $60.00 in 1980 to $75.00 in 1983 (an increase of 25 percent).

2. Coinsurance (Part B) :
   Actual per capita coinsurance charges borne personally by the elderly increased by 345 percent between 1972 and 1982.
3. Cost-sharing (Parts A and B) :
   In 1981, out-of-pocket payments for both the inpatient deductible and coinsurance liability constituted over 14 percent ($5.3 billion) of all hospital expenditures, a 23 percent increase in out-of-pocket payments since 1977.
4. Charge reductions on unassigned claims (i.e., the difference between the Medicare "allowed" charge and the actual charge by the physician for which the beneficiary is personally liable):
   Between 1977 and 1982, the total dollar amount of "charge reductions" passed on to elderly Medicare beneficiaries jumped from $674,000,000 to $2,006,000,000 (an increase of 198 percent over a five-year period).

   Approximately 46 percent of all Part B claims submitted to Medicare for reimbursement at this time are "unassigned", compared to an over-50 percent non-assignment rate in 1977. Nevertheless, beneficiary liability for "unassigned" claims has increased dramatically over the past five years even though the number of claims paid on assignment has increased during the same period.

5. Non-covered services:

   Aged Medicare beneficiaries are personally liable for a significant number of critical non-covered services and products -- including dental services, dentures, prescription drugs, eye glasses, hearing aids, etc. -- for which they paid about 7 billion out-of-pocket in 1981, a 60 percent increase in their out-of-pocket liability for such products and services since 1978.

6. Coinsurance for Skilled Nursing Home Care and charges for all ICF care:

   Approximately half of all nursing home expenditures made on behalf of the aged were financed directly by out-of-pocket payments in 1981. As HCFA researchers have noted: "Even if other sources comprised half of the total payments, the average out-of-pocket expenditure for private-paying patients would still be over $100 per week."

7. SMI (Part B) Premiums:

   Out-of-pocket premium payments by the elderly for Medicare Part B coverage totalled $78 annually in 1977 as compared with a current annual figure of $175.20 a 125 percent increase in SMI premium payments by the elderly over the past seven years.

8. Private Health Insurance Premiums:

Approximately 65 percent of aged Medicare beneficiaries are sufficiently concerned about the gaps in Medicare coverage to purchase private health insurance policies designed to supplement medical expenses. Currently, low option private insurance plans cost aged Medicare beneficiaries approximately $230 per year, while high option plans cost roughly $700 per year. These figures compare with an annual private insurance premium rate of $90 just five years ago.

Finally, there is evidence to suggest that fewer and fewer of the elderly are financially able to retain such supplemental policies once they are purchased. Blue Cross/Blue Shield of Florida has recently pointed out that the "persistency rate" (i.e. the percentage of those aged beneficiaries who had coverage at the beginning of the year and continue to have coverage at the end of the year) has dropped from 93.3 percent in 1978 to 86.9 percent in 1982.

Persons aged 65 and over paid roughly $700 out-of-pocket per capita for medical expenses in 1977. By 1983, this amount had increased by over 120 percent to $1550 per capita, equalling 15 percent of the annual per capita income of the aged ($10,615). The current proposals to increase beneficiary cost sharing impact most directly those aged beneficiaries least able to bear the burden: they do nothing to address the forces driving health sector inflation -- uncontrolled growth in health care costs.

Out-of-pocket costs just for Part B

Under existing law, Medicare beneficiaries have substantial responsibility for the cost of physician services. Beneficiaries must pay the annual Part B deductible of $75, plus 20 percent coinsurance on all reasonable, customary, and prevailing physicians' charges. Between 1972-1982, incurred coinsurance charges increased by approximately 345 percent. Moreover, beneficiaries are liable for all charge reductions associated with unassigned physicians' claims. In 1980, aged beneficiary liability resulting from unassigned claims exceeded $1.3 billion, an amount representing 13 percent of _total_ physicians' charges for the elderly that year.

Beneficiary liability for physicians' services results, of course, not only from unassigned claims, but also from deductible and coinsurance charges. These three charge components--charge reductions associated with unassigned claims, deductible, and coinsurance--together represent "variable beneficiary liability" for physicians' services. In 1980, such variable liability for the aged amounted to nearly 35 percent of total physicians' charges due. Further, if Part B premium payments representing a form of "fixed beneficiary liability" are combined with "variable beneficiary liability" for 1980, the net _Medicare_ contribution against total physicians' charges falls to only 45 percent, the aged beneficiary being responsible for the remaining 55 percent of charges due the physician. It is estimated that total beneficiary liabilty for physicians' charges due under Medicare have increased to over 60 percent in 1983.

CURRENT PROPOSALS TO RESTRUCTURE PART B

The Congress and others have been considering several proposals to restructure Part B of Medicare with a view toward limiting reimbursements to physicians. While there are strong equity arguments upon which to base such changes in Part B, the reality of enforcing such a limitation, for most of these proposals, results in greater beneficiary costs, not a limitation on the increase in physician fees. Hence, most of the currently debated proposals for restructuring Part B are in reality a reduction in Medicare benefits, NOT physician fees.

There are currently four major proposals being considered by Congress to limit Part B expenditures. They are:

1. The Administration's proposal to freeze physician reimbursements for a year. While some may regard this proposal as a cut in provider reimbursements, AARP believes it will instead increase beneficiary out-of-pocket costs. Under the proposal, physician fee screens, i.e., reasonable, customary, and prevailing charges, would not be updated in fiscal 1985 as

usual, eliminating the yearly increase for that year. Physicians would totally lose one year of inflation protection. A yearly increase in physician fee screens would not occur until 1986.

2. The Social Security Advisory Council's proposal to require physicians to decide each year whether to always accept assignment (participating) or never accept assignment (non-participating) for all Medicare patients. Participating physicians would be identified in a directory and given streamlined billing and claims procedures. All claims of beneficiaries receiving services from non-participating physicians would be unassigned.

3. The Senate Finance Committee's proposal to freeze physician fees coupled with a participating physician program. Specifically, the proposal would freeze prevailing fees for all physicians for three months beginning April 1, 1984. After this three-month freeze (beginning July 1, 1984), the freeze on prevailing fees would end for physicians who become "participating" physicians, that is, physicians who agree to accept assignment for all Medicare services for the following fee screen year (July 1984 to June 1985). For those physicians who choose to remain "non-participating" physicians, the freeze on prevailing fees would continue for an additional two years. Non-participating physicians would still have the option to accept assignment on a claim-by-claim basis. To encourage physicians to become participating physicians, incentives, such as physician directories, toll-free hot lines, electronic billing transmission, and simplified payment arrangement for those with

both Medicare and Medigap coverage, would be provided.

AARP supports additional incentives to encourage physicians to accept assignment. Toward that end, AARP supports electronic billing, multiple claims, simplified payments, and the like. We are deeply concerned, however, that these three proposals will:

(a) erode the number of physicians willing to accept assignment;

(b) increase beneficiaries' out-of-pocket costs; and

(c) likely increase hospital costs.

Freezing physician fee screens unless a physician agrees to accept assignment on all claims, will significantly widen the gap between Medicare allowable charges and physician actual charges. The likely result is a dramatic drop in an already low assignment acceptance rate.

Currently, only 20 percent of all physicians accept assignment in all cases. Thirty percent (30%) never accept assignment. Only 54 percent of all claims submitted to Medicare are submitted by physicians as "assignment" claims. The other 46 percent of claims are non-assigned, leaving beneficiaries responsible for paying the difference between the Medicare allowable charge and the physician's actual charge (charge reductions). In the last five years, "charge reductions" passed on to beneficiaries have risen nearly 200 percent.

Moreover, sixty-nine percent of the physicians responding to a 1982 survey by the American Medical Association identified inadequate Medicare reimbursement as an important reason for their not accepting assignment. In 1971, President Nixon froze wages and prices (including physicians' fees) under the Economic Stabilization Act (ESA). Between August 1971 and April 1974, while the ESA was in force, the physician assignment rate fell more than eleven percent. And despite the freeze, physician fees rose sixteen percent during the same period.

For most of its effective life the ESA restricted increases in hospital costs per admission and in physicians' charges per procedure but did not restrict increases in hospital admissions or in total physician services. Since ESA had no effective limitation on the volume of services, the data indicate that hospitals and physicians responded to the ESA by allowing hospital admission rates to increase. If the proposal to freeze physician reimbursements becomes law, it is likely that both hospital admissions and total physician services will increase, resulting in even higher government expenditures for health care.

Plans calling for participating physician agreements offer no assurance against a decline in the overall Medicare assignment acceptance rate. In fact, such proposals, even without a physician fee freeze, run a serious risk of actually decreasing the already low assignment rate and thus adding even more to beneficiaries' out-of-pocket costs. A 1983 HCFA study found that the overall assignment rate would fall by at least ten percent if an "always or never" system like the one offered in this proposal were put into place.

AARP cannot support the three proposals described above because they do not provide any mechanism to ensure that physician fees would indeed be limited without physicians' shifting the amounts limited onto Part B beneficiaries. The House Committee on Ways and Means is considering a proposal, however, that both limits increases in physician fees and ensures that those costs will not be shifted to Part B beneficiaries. Popularly known as the "Rangel Amendment" the proposal requires hospitals, as a condition of participation in Medicare, to obtain signed agreements from their affiliated physicians affirming that the physicians will accept assignment for all inpatient physician services.

AARP supports mandating Part B assignment for inpatient physician services as a condition of participation for hospitals in Medicare because two-thirds of Medicare allowable charges for physician care go for inpatient services. In addition, charge reductions for unassigned claims associated with inpatient physician care constitute 60 percent of beneficiary liablity for unassigned claims. Mandating assignment for Part B inpatient services wouuld reduce the high out-of-pocket costs associated with inpatient physician care. Moreover, requiring hospitals to secure physician agreement to accept inpatient assignment as a condition of the hospital's participation in Medicare provides an effective mechanism for ensuring that costs will not be shifted to Part B beneficiaries. AARP views the "Rangel Amendment" as a modest but necessary modification in the Part B program. On March 15, 1984 Congressman Roybal, Chairman of the House Select Committee on Aging, introduced legislation that extends the Rangel amendment mandate for inpatient assignment to outpatient assignment too. AARP favors this expansion of protection.

THE DEVELOPMENT OF A MORE STABLE AND EFFECTIVE SYSTEM OF INCENTIVES FOR PAYMENT OF PHYSICIAN SERVICES

The crises in the medicare trust funds is merely a reflection of the crises in the larger health care sector of the economy. Physicians, like hospitals, have flourished under perverse reimbursement mechanisms that have perpetuated historical disparities between cognitive and procedural services and that have created incentives for physicians to overutilize the system. Proposals to freeze physician fee screens, mandate assignment, or develop "participating" physician schemes, do not address the underlying physician cost problem. Such proposals are merely feeble attempts to moderate the financial pain caused by the fee-for-service system. AARP is concerned that such proposals offer too little, too late to keep the system affordable and therefore accessible for all Americans. Physicians, like hospitals, must begin to share more of the financial risk created by modern, high technology medicine.

It is now generally understood that the cost-plus and fee-for-service reimbursement system is inherently inflationary. No amount of marginal reform can change the basic inflationary incentives inherent in the fee for service system. Thus, policy makers must seriously consider a prospective pricing approach to physician payments. AARP is not wedded at this time to any particular method of establishing a prospective payment system for physicians. We support timely enactment of the concept with actual implementation occuring after adequate consideration of the appropriate prospective payment methodology.

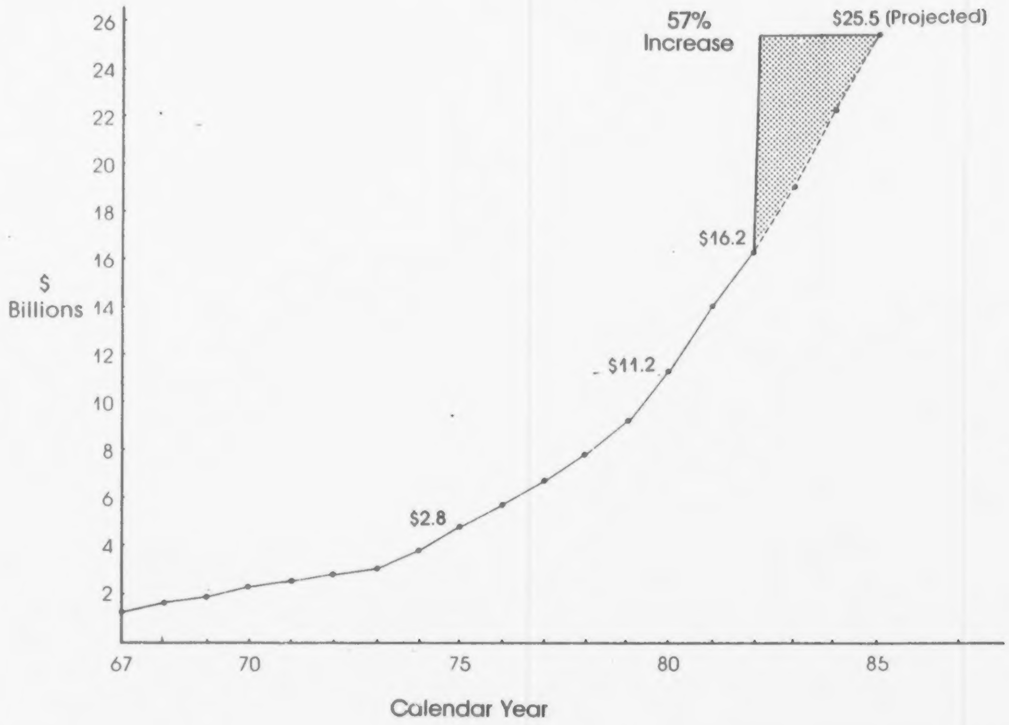
Moreover, AARP believes that the prospective payment system for physicians must address the bundle of incentives created by the relatively high levels of compensation for technologically intensive diagnostic services compared to cognitive services. For too long, the discrepancy in payment for technological procedures over cognitive services has unnecessarily inflated physician care expenditures by fostering overutilization of technology-intensive ancillary procedures and by inducing physicians to enter the more procedure oriented specialities. AARP believes that encouraging and rewarding the application of thought rather than technology will have a moderating effect on costs.

CONCLUSION

The SMI trust fund, like the Part A trust fund, is heading for disaster because revenues are not keeping pace with expenditures. Proposals to freeze physicians' reimbursement or mandate assignment do not address the underlying forces driving Part B costs, they merely shift program costs to beneficiaries who are already paying about 60 percent of their physicians' bills directly out-of-pocket.

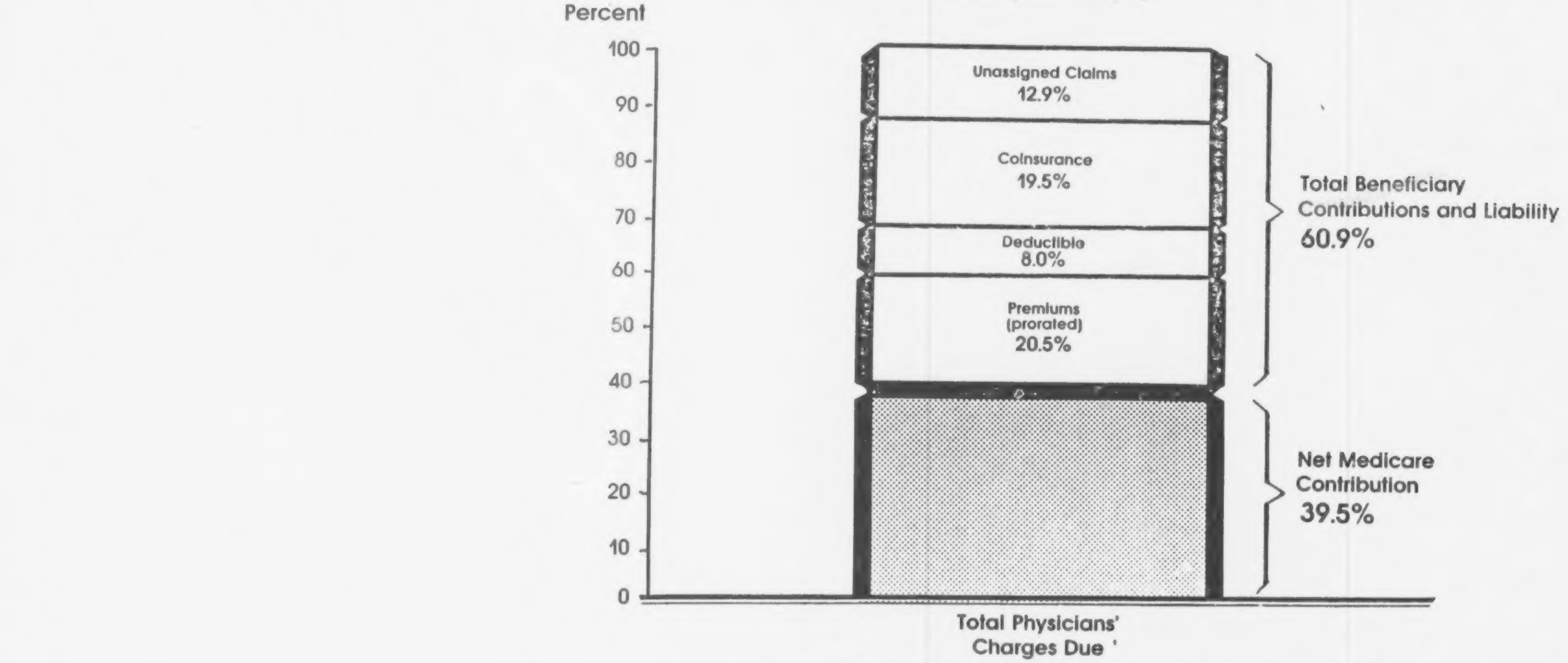
In the short term, AARP favors requiring hospitals to make their affiliated physicians accept inpatient assignment as a condition of the hospital's participation in Medicare. This proposal substantially reduces the physician's ability to shift costs and provides adequate assurance that beneficiaries will maintain access to care. Over the long term, AARP favors a prospective payment system for physicians services. In addition, policy makers must begin to address the gap in compensation for technological procedures over cognitive services. Such subtle, but powerful incentives must be corrected if we are to maintain affordable and accessible health care services for all Americans.

Medicare Part B Supplementary Medical Insurance Expenditures



Source: 1983 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance (SMI) Trust Fund

TOTAL PHYSICIANS' CHARGES DUE:
COMPARISON OF REIMBURSEMENT WITH NET MEDICARE CONTRIBUTION FOR THE AGED
1983 (Estimated)



[1] Total exceeds 100% due to rounding

Source: AARP estimates based on data [illegible] the Office of Management and Budget

ANNUAL HEALTH CARE PAYMENTS MADE BY THE AGED

	Per Aged Person	Payments as a Percent of Income
1966 (Pre-Medicare)	$300	15%
1977	$698	12%
1981	$1198	14%
1984	$1550	15%
1989	$2208	16%
1993	$2892	17%
2000	$4637	19%

Source: Health Care Financing Administration, American Association of Retired Persons

Chairman HEINZ. Bill Hutton.

STATEMENT OF WILLIAM R. HUTTON, WASHINGTON, D.C., EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. HUTTON. Thank you, Mr. Chairman.

I appreciate this opportunity to appear before you today on behalf of the more than 4 million medicare beneficiaries who are members of the National Council of Senior Citizens.

The subject of part B coverage and related physicians' fees is one about which our members write to us perhaps more than any other medical issue. We are not surprised, since medicare part B covers only 56 percent of the elderlys' doctor bills.

We are distressed, however, about the high prices older people must pay out-of-pocket to be eligible for this partial protection.

I would appreciate it very much, Mr. Chairman, if I could submit the entire testimony which is before you, to enter into the record.

I will concern myself in the next 2 or 3 minutes with some highlights.

One of the most widespread and the greatest financial burdens imposed on elderly persons is physicians' billing of additional fees because they do not accept assignment. That is, they do not accept medicare's approved charge as payment in full. This additional shifting of costs from physicians to their medicare patients is estimated at $2.5 billion over and above the medicare premium deductible and coinsurance beneficiaries pay each year. People still seem to believe that medicare pays 80 percent of the doctor's bill and that the patient only pays 20 percent.

To illustrate, let me read a part of a letter one of our members sent to us last October. It is a copy of a letter she sent into the New York Times. She said:

> I am writing to correct a gross inaccuracy in your editorial on October 12, entitled "What Is Fair In Medicare," in which you stated that medicare pays 80 percent of physicians' fees.

She said that this was a popular misconception.

> Let me give you the facts. On the June 23, 1982, my physician performed a skin biopsy for which I paid his fee of $125. Medicare approved only a fee of $62, $50 of which was reimbursed, 80 percent, namely, $50. On July 6, 1982, surgery to remove skin cancer was performed for which I paid a fee of $350. Medicare approved a fee of $316, which I received 80 percent reimbursement, $253.

And so she explained that any accountant would testify that the total reimbursement is very much less than the 80 percent which the New York Times claimed at that time, and which, in fact, everybody who goes to the hospital knows that that just ain't so.

The problem of rising medical hospital insurance—HHR—and supplementary medical insurance—SMR—costs can be achieved. I was very much interested in Dr. Reinhardt's comment this morning that, in fact, we have almost reached a level where we can go no further in cost shifting onto the patient's back, particularly older people living on reduced incomes.

The new medicare prospective payment system for hospitals may be a step in that direction, the direction of not shifting rates. But we are not really sure. There are already signs that the hospitals are learning how to game the new system to benefit the institutions and at the expense of patients, and at the expense of the Federal Government. That is something which you are going to learn about in the future as we gather more and more information.

But it seems already the hospitals are turning pretty smart on the new system.

The President's fiscal 1985 budget plan and the Senate Finance Committee's budget and deficit reduction proposals illustrate cost and responsibility shifting at its absolute worst. We commend you, Mr. Chairman, and your Finance Committee colleagues, Senators Bradley and Matsunaga, for your sensitivity to the beneficiaries' needs by opposing an outrageous increase in the part B premium.

Unfortunately, your other colleagues on the committee adopted the provision which would double the premium in only 3 years, and triple it in 5 years.

If the Finance Committee and their colleagues in the Senate believe they are taking a fair and balanced approach by freezing physicians' reimbursements and also asking beneficiaries to pay higher premiums again—higher premiums and higher deductibles—well, they are very mistaken. It is really grossly unfair.

Chairman HEINZ. Bill, if I may interrupt you, I felt a little lonely out there, just Bill Bradley, Matsunaga, and myself, 20 percent of the committee opposing it. But I would predict on Tuesday virtually every member of the Committee will join us.

Mr. HUTTON. They are beginning to see the light, Senator. I hope you are right.

Well, as I say, we believe that the fair, responsible, and effective approach to controlling rising medicare part B outlays would be to slow the rising cost of physicians' services. You have assembled a panel of technical experts to discuss this issue. I thoroughly enjoyed Dr. Reinhardt. He makes me feel that economics is not that kind of a dismal science, anyway. He makes an awful lot of fun out of it.

We urge you to continue your dialog in this until reasonable reimbursement reform which is fair to the beneficiary and the physicians can be adopted.

Thank you very much for the issue. I thank you for the proposal. And I can assure you that the national council will do its best to support you through the coming year.

Chairman HEINZ. Bill, thank you very much.

[The prepared statement of Mr. Hutton follows:]

Medicare Physician Payments

Statement by

William R. Hutton, Executive Director
National Council of Senior Citizens
925 15th Street, N.W.
Washington, D.C. 20005

before the

U.S. Senate Special Committee on Aging

March 16, 1984

Mr. Chairman, Members of the Committee, I am William R. Hutton, Executive Director of the National Council of Senior Citizens. I appreciate the opportunity to appear before you today on behalf of the over 4.5 million older persons that NCSC represents throughout the country. We believe that any discussion of physicians' fees and options for the Medicare program must include consideration of the elderly beneficiaries' perspective. If Congress makes recommendations regarding Part B Supplemental Medical Insurance (SMI), these recommendations not only must be sensitive to the medical and financial needs of the elderly, but also must be designed to achieve economic efficiency within the Medicare program.

The subject of Part B coverage and related physicians' fees is one about which our members write to us perhaps more than any other medical issue. We are not surprised since, as the Health Care Financing Administration reports, Medicare covers only 56 percent of the elderly's doctor bills. We are distressed, however, at the high price older people must pay out-of-pocket to be eligible for this partial protection.

The impact on the beneficiary of Part B's inadequacy can be illustrated by a comparison to Part A, Hospital Insurance coverage. Except for a very high deductible of $356 per benefit period, Part A's coverage of the average older person's hospital stay (11 days) is very good. No additional out-of-pocket expenditures are required for covered services until the sixty-first day of hospitalization during a benefit period. Thus hospital insurance protects the elderly from what could otherwise be the catastrophic expense of a short stay in the hospital. Since about one of every four beneficiaries is hospitalized each year, the Part A benefit actually applies to a relatively small, though acutely ill, number of beneficiaries.

In contrast, about four out of five Medicare beneficiaries visit the doctor each year, and 70 percent of beneficiaries incur Part B covered expenses. Since the beneficiary cost sharing required under Part B is so great, the financial liability of the average older person with chronic illness can be far greater than that under Part A. For example, before Medicare will reimburse for physician services, the beneficiary must first pay $251; $176 goes toward the annual premium and is deducted in monthly increments from the Social Security cash benefit check; $75 worth of covered services are then counted toward meeting the annual deductible. That's only the beginning.

Once these "cost-sharing" requirements have been met, Medicare pays for only covered services and at 80 percent of the approved charge for these services. The beneficiary pays not only 20 percent of approved charges, but also 100 percent of the difference between the physician's fee and the Medicare approved charge. The beneficiary is liable as well for 100 percent of all uncovered services such as prevention related check-ups, routine foot care, and prescription drugs.

One of the most widespread and greatest financial burdens imposed on elderly persons is physicians' billing of additional fees because they do not accept assignment. That is, they do not accept Medicare's approved charge as payment in full. This shifting of cost from physicians to their Medicare patients amounted to $1.4 billion in 1982 according to the Health Care Financing Administration, and is now estimated to be over $2 billion.

Medical inflation and Medicare's mandated cost sharing are severe enough problems for older persons, but they also face mounting problems related to the Congress' and the public's insufficient understanding of Part B's shortcomings. People still seem to believe that Medicare really pays 80 percent of the doctors' bill and that the patient pays only 20 percent. Ask most senior citizens what the payment ratio is and you will get a much more realistic answer. To illustrate, let me read part of a letter one of our members sent to us in October 1982. It was a copy of a letter she sent to the editor of The New York Times:

> "I am writing to correct a gross inaccuracy in your editorial of October 12, entitled 'What's Fair in Medicare,' in which you state that Medicare 'pays 80% of physicians' fees'. This is a popular misconception, and does violence to the interests of senior citizens.
>
> "Let me give you the facts: On 6/23/82, my physician performed a skin biopsy, for which I paid his fee of $125. Medicare approved a fee of $62.50 of which I was

> reimbursed 80%, namely $50. On 7/6/82, surgery to remove a skin cancer was performed, for which I paid a fee of $350; Medicare approved a fee of $316.90, for which I received the 80% reimbursement of $253.52. I believe that your accountant will testify that total reimbursement was very much less than the 80% you claim."

If one believes that the beneficiary pays only 20 percent of doctors' fees, then proposals to increase the premium or deductible or even freeze doctors' payments may not sound too burdensome. However, if one considers the current obvious costs such as the premium and deductible and the hidden costs such as those associated with non-assignment, the burden is already excessive. Yet in the last few years, Congress has increased that burden for the sake of Federal budget reduction. These steps have served only to hurt older people, while preserving the incentives and the practices which feed inflation in physicians' fees and contribute to unprecedented growth in Part B outlays.

Mr. Chairman, we do not believe that Medicare benefits or cost-sharing levels should be used as instruments to reduce the budget deficit or Federal outlays. The Medicare program and Federal fiscal matters certainly both need Congressional attention and possible reform. However, they are not necessarily related, nor should they be treated as cause and effect. Moreover, slowing Medicare Part B outlay increases in this context is unlikely to have any long-term effect on the Federal deficit, the impending Hospital Insurance Trust Fund insolvency, or the real problem of health system-wide costs.

We encourage Congress to examine the rapid growth of Medicare program costs in recent years. We urge you to examine carefully reimbursement methods as a factor in this growth and their effect on the beneficiary. As Medicare outlays increase, mandated cost-sharing levels rise. As medical inflation continues its relentless attacks on the Medicare program and benefit adequacy, the problem grows.

Since the needed control through health system cost containment has not been enacted, the Congress and the Administration have directed Federal "savings" proposals to the beneficiary. This approach views Medicare as a cause of Federal deficits rather than a Federal program in which outlays are increasing at an unnecessarily rapid rate due to inflation and cost-increasing incentives driven by delivery and payment mechanisms. We believe this approach is irresponsible public policy, as well as poor aging policy. Shifting additional costs to the beneficiaries has not and cannot slow down medical price increases which continue to far out-pace the Consumer Price Index.

Therefore, the National Council of Senior Citizens asks Congress to solve the problem of rising Medicare Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) costs, without shifting additional financial risks to the beneficiary. The new Medicare prospective payment system for hospitals is a step in that direction for HI. Although we are concerned that the hospital's response to limited payment may not always be in the beneficiaries' best interest, and that the plan is applied only to Medicare, thus allowing cost shifting to other payors, we believe that the plan is significant in at least two respects. It recognizes that rising hospital costs are the major cause of the Hospital Insurance Trust Fund's rapidly increasing outlays and threatened insolvency. It appropriately directs the solution toward the major cause of the problem: hospital reimbursement methods and the economically inefficient practices they encourage. The patient is rightfully not given responsibility, financial or otherwise, for solving the problem.

Such is not the case with the Part B proposals issued in recent years by the Administration, those which have been adopted by the Congress, and others which have been recommended by Congressional Committees. The President's FY 1985 budget plan and the Senate Finance Committee budget and deficit reduction proposals, for example, illustrate cost and responsibility shifting at its worst. The majority of "savings" these plans purport to achieve would be derived from beneficiaries through increased deductibles, premiums, and costs shifted from physicians whose payment levels would be frozen.

We commend you, Mr. Chairman, and your Finance Committee colleagues Senators Bradley and Matsunaga for your sensitivity to the beneficiaries' needs by opposing an outrageous increase in the Part B premium. Unfortunately, your other colleagues on the Committee adopted this provision which would double the premium in only three years and triple it in five years. If the Finance Committee members and their colleagues in the Senate believe they are taking a fair and balanced approach by freezing physician reimbursements and also asking beneficiaries to pay higher premiums and deductibles, they are mistaken.

Current Medicare law allows physicians to accept assignment at their discretion, that is, all of the time, on a case-by-case or patient-by-patient basis, or not at all. Physicians indeed exercise their option, as Health Care Financing Administration data reveal:

- Only 18 percent of physicians accept assignment on all cases, and 30 percent never accept assignment. A vast array of assignment rates occurs between these two extremes.
- Nationwide average assignment rates in 1982 ranged from a low of 19 percent in Wyoming to a high of 82.9 percent in Rhode Island.
- 53 percent of Medicare claims filed in 1982 were assigned.
- 78 percent of Medicare beneficiaries who incurred Part B expenses in 1979 filed unassigned claims.

Thus, freezing physician payment rates may temporarily slow Medicare spending, but it would freeze only the amount of money Medicare pays physicians, not the amount that physicians can charge their elderly patients. Although a modification of assignment requirements could be implemented to protect the beneficiary, and we do not support a freeze without assignment, let me stress that freezing payment is not true cost containment. Physicians could increase volume to maintain income or increase fees after the freeze to make up for the lost income.

We believe that the fair, responsible and effective approach to controlling rising Medicare Part B outlays would be to slow the rising cost of physician services. As with the problem of controlling HI expenditures, we urge you to recognize SMI expenditure growth not as a Medicare specific problem, but one which is a part of, and affected by, factors in the broader health system.

Working toward an across-the-board cost-control plan which includes all payors and providers and which encourages states to adopt their own plans, we believe, would have a long-term effect on slowing the rate of medical cost increases, would assure Medicare solvency, and would avoid placing greater financial risk on people who need health services. The Kennedy/Gephardt Health Care Cost Containment and Medicare Solvency Act of 1984 is such a plan. We urge your support for this bill.

In the meantime, reimbursement changes in Medicare's payment to physicians should be made to slow the rate of provider charge increases and protect the aged and disabled beneficiaries. You have assembled a panel of technical experts to discuss this issue today, and we urge you to continue your dialogue with them and others until reasonable reimbursement reform which is fair to the beneficiary and the physician can be adopted.

Let me reiterate our position. We believe that one of the objectives of reform should be to better spend the Supplementary Medical Insurance dollar. Attempting to slow Part B spending for short-term budget savings by shifting additional costs to the beneficiary hurts the elderly. In addition, it is not cost containment, as continued Part B annual outlay increases of 18 percent illustrate. We urge Congress to examine the entire physician reimbursement structure of Medicare. We encourage you to evaluate such options as: altering payment for in-hospital services, for example, by combining HI and SMI payments for such services; reducing the payment differentials between services which utilize highly technical procedures and those which do not or differentials between various medical specialities; applying prospective methodologies to physician payments.

Discussion of physicians' fees and Medicare reimbursement must include the question of Medicare assignment. The handling of assignment relative to physician reimbursement reform is critical because the limitations which will be placed on physicians' Medicare income will translate into increased patient costs without the protection that Medicare assignment provides to the beneficiary.

As with the other proposals we are discussing today, assignment must be considered in the context of changes in physician payment methods whether they be short-term freezes or a part of the broader reform needed for total health system cost savings. I will now identify NCSC's position on a variety of proposals.

1. No change in current assignment option.

   As noted, beneficiaries pay about $2 billion out of pocket for services not billed under assignment. If Medicare reimbursement is further limited, we believe assignment rates will decrease and physicians' services will become even more costly to the elderly person. Therefore, we favor a change in current assignment law.

2. Mandatory assignment for all Medicare cases/patients.

   We support the theory of mandatory assignment as financial protection for the beneficiary. However, we recognize the practices it may encourage and the access limitations which may result without additional beneficiary protections. Therefore, we recommend a thorough assessment of a mandatory assignment plan, for example, through demonstration projects which include the use of incentives for physician participation, the involvement and recommendations of fiscal intermediaries, possible varied application between in- and out-patient services, and the implementation of reimbursement reform.

3. Mandatory assignment for all participating physicians; optional assignment for non-participating physicians.

   This variation on assignment attempts to address the problem of reduced access which could result from mandatory assignment. We support the approach, but believe it is weaker than other options. The financial protection it provides to the beneficiary, especially in the short term, is incomplete because of the optional element. This plan could be strenghened considerably by the extent of physician incentives it includes.

4. Variations on Assignment.

Perhaps the most frequently discussed assignment option is to require physicians to accept assignment for payment of hospital in-patient services. We support this approach, which has been incorporated into both the Kennedy/Gephardt bill and what is now called the House Ways and Means Committee Amendment, or the Rangel Amendment. This approach to mandatory assignment is reasonable and we believe it could be effective. It represents a phase-in of mandatory assignment, discourages physicians from not participating, coincides with a case approach to payment, and allows time to evaluate methods for requiring assignment on out-patient services.

Thank you for the opportunity to express the National Council of Senior Citizens' views. I will be happy to answer questions.

Chairman Heinz. Dr. Todd.

STATEMENT OF DR. JAMES S. TODD, RIDGEWOOD, N.J., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY ROSS N. RUBIN, DIRECTOR, DEPARTMENT OF FEDERAL LEGISLATION, AMA

Dr. Todd. Thank you, Mr. Chairman.

I am James S. Todd. I am a physician in the practice of general surgery in Ridgewood, N.J., and I am a member of the American Medical Association's board of trustees.

Accompanying me is Ross N. Rubin, director of the AMA's department of Federal legislation.

We appreciate this opportunity to present testimony today on the subject of physician reimbursement under medicare and reimbursement options for physicians' services.

The vast majority of physicians in the Nation participate freely in the medicare program through their treatment of medicare beneficiaries. This large scale participation provides access to necessary health care services for the elderly that is equal to any other population group in the country.

Even though the level of physician reimbursement under the medicare program has not kept pace with the rest of the economy and other reimbursement mechanisms, the percentage of physicians treating medicare patients has remained relatively constant, with 87.1 percent of physicians treating medicare patients in 1982.

On March 2, the American Medical Association sent a letter to every physician in the country urging each to voluntarily freeze his or her fees for 1 year period, and to continue to take into account the financial circumstances of each patient, especially the unemployed, the uninsured, those under medicare, and to accept reduced fees when warranted.

In a November 1, 1983, letter to all members of the House of Representatives, the AMA has pledged to ask physicians to refrain from passing on additional costs to their elderly patients, to urge all physicians to be considerate to the needs of their patients, and to avoid increasing the financial burdens of their patients.

The voluntary freeze proposed by the AMA applies to all physicians and applies to all of a physician's patients, not just those who are covered by medicare.

We believe that this step will be especially helpful in easing the current deficit problems facing the Federal Government. The AMA recognizes that one of the major concerns of this committee is the amount of personal liability individual medicare recipients experience when faced with a physician's bill for services. We also are concerned about such costs, and we believe that it is important to point out the following facts.

First, a substantial portion of individual liability is directly related to the mandated deductible and coinsurance requirements under law and the amount often paid by medicare insurance.

Second, physician charges to medicare beneficiaries are in harmony with charges to nonmedicare beneficiaries.

Third, the total portion of beneficiary payments for deductibles and coinsurance decreased from 32.3 percent for total physician service in 1968 to only 20.6 percent of total physician service presently.

Fourth, while approximately 78 percent of the aged population in 1978 who received medicare payment for physician's services did experience some liability exceeding the deductible and coinsurance amounts under unassigned claims, only about 15 percent of this population have liability of $100 or more.

Fifth, the application of economic index has served to arbitrarily increase beneficiary liability.

And, sixth, approximately two-thirds of all elderly medicare beneficiaries have some form of medicare supplemental coverage.

There have been many proposals in recent years to modify physician reimbursement under the medicare program. The AMA has reviewed these proposals, and we will discuss our concerns about some of them.

The administration, Senate Finance Committee, and the House Ways and Means Committee have all prepared various types of freezes on physicians' fees under medicare. A 1-year freeze of medicare payments to physicians as proposed by the President in his recent budget would indeed be in line with our association's recent action urging physicians to voluntarily freeze their fees for 1 year period.

In our opinion, the current system where physicians have the option to assignment on a claim, the claim basis has been used properly, and it should be allowed to continue.

Of the nearly 90 percent of physicians that treated medicare patients in 1982, approximatly 70 percent of these physicians accepted some claims on an assigned basis. Also, the percent of physicians who do accept assigned claims has actually increased from the 61 percent in 1978 to approximately 70 percent in 1982.

It must also be remembered that the medicare program is not intended to be a welfare program. In the development of the medicare program, Congress specifically considered the issue of access and the fact that the program is not means-based in giving the physician the option to bill directly or to accept assignment.

Because the physicians have the choice to accept or not accept assignment, medicare beneficiaries are in turn able to select a physician from virtually the entire physician population.

A change in the assignment policy, especially in light of a proposal to further hold down medicare part B reimbursement could affect the access of medicare patients to the physician of their choice. Indeed, a paper prepared pursuant to a grant from HCFA and published in December of 1983 issue of "Health Care Financing Review" indicates that if physicians were placed in a position of having to decide whether to accept all or none of their medicare patients on an assigned basis, that over two-thirds of physicians would take no assignments.

That would result in a drastic reduction in assignment rates nationwide.

It is also important to note that assignment rates increase in situations where average annual charges per user increased. The percent of services assigned and the percent of total charges assigned similarly increases as beneficiaries grow older. This is particularly significant as medicare reimbursement for figures and other medicare services increase with age.

Statistics cited in our formal statement indicate that most individual beneficiaries are not being faced with high levels of personal liability for physician charges. For those individuals who used part B services in 1979, 64.9 percent of them have a total use of liability of less than $150 for each person.

Another proposal related to acceptance of medicare assignment that has been under consideration is the so-called participating physician concept. While such proposals may be attractive on their face, they pose numerous problems.

First, the elderly would be given the mistaken impression that only physicians indicated on the list as participating physicians, would be eligible to provide service to medicare beneficiaries. It also fails to recognize situations where physicians may accept assignment for a substantial percentage of their medicare case load, while continuing to bill full charge to those patients in their practices who can afford to pay the full charge.

Another concept for physician reimbursement that has been discussed is to base payments for physician services on DRG's. This concept is to be the focus of a congressionally mandated study that is due in September of 1985. Pending the outcome of the study, we believe it premature to consider this modification in physician pay.

Just as the AMA has concerns over the hospital DRG payment program, we have concerns with the DRG based physician payment plan. Even if such a plan were feasible, we have grave questions on how it would impact on the quality of care. While we do not expect that physicians would consciously limit the care that they provide, the DRG system could indeed give substantial economic incentives to provide minimal care.

The DRG methodology of payment also concerns us because of its failure to take into account the severity of illness. And this fact could be especially troublesome for highly skilled physicians who, because of their specialized skill and training, attract patients with the most severe illnesses.

The American Medical Association recognizes that the medicare program and part A program in particular are heading for a fiscal crisis in the next decade. Accordingly, the AMA board of trustees has directed that two of its councils, council on legislation and council on medical service, try to develop a program that would help assure the long-term solvency of the medicare trust funds.

In this review of the medicare program, all aspects will be studied, and we fully expect to examine the methodology of payment to physicians as well.

The American Medical Association is committed to the provision of the highest quality of care for medicare beneficiaries. We firmly believe that the beneficiaries generally have received high quality of services from physicians at the appropriate costs. We fully expect that this record will continue into the future.

Thank you, Mr. Chairman.

Chairman HEINZ. Thank you very much, Dr. Todd.

[The prepared statement of Dr. Todd follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Special Committee on Aging
United States Senate

RE: Physician Reimbursement Under Medicare
— Reimbursement Options

Presented by

James S. Todd, M.D.

March 16, 1984

Mr. Chairman and Members of the Committee:

I am James S. Todd, M.D. I am a physician in the practice of general surgery in Ridgewood, New Jersey, and I am member of the American Medical Association's Board of Trustees. Accompanying me is Ross N. Rubin, Director of the AMA's Department of Federal Legislation. The American Medical Association appreciates this opportunity to present testimony today on the subject of physician reimbursement under Medicare and reimbursement options for physician services.

Before examining the issue of physician reimbursement under Medicare, we believe it is essential to examine Medicare's purposes and accomplishments. The creation of the Medicare program in 1965 was a commitment to the elderly by the Congress that this nation would assure them access to, and meet the major part of the cost of, high quality health care services. That promise, to a large extent, has been met. The eighteen years since the enactment of Medicare have seen tremendous improvement in not only access to and the availability of high quality health care, but in the health care status of the covered population. One of the principal reasons why the Medicare program has been able to accomplish these important twin goals of ready access to high quality care and improved overall health status has been the ability of the Medicare beneficiary to receive care in the same mainstream fashion as other individuals not covered by federal programs.

Physicians have chosen to participate freely in the Medicare program through their treatment of Medicare beneficiaries. Even though the level of physician reimbursement under the Medicare program has not kept pace with the rest of the economy and other reimbursement mechanisms, the percentage of physicians treating Medicare patients has remained relatively constant, with 87.1% of physicians treating Medicare patients in 1982.

The American Medical Association realizes that the Medicare program experiences substantial outlays for physician services. This reflects the fact that the current population of the program is estimated to include 26.6 million elderly and 2.7 million disabled, and it is further estimated that 18.4 million aged and 1.8 million disabled beneficiaries will receive covered services this year. This segment of the population reflects a group with significantly greater needs for medical services than does the population as a whole. Expenditures for the Part B program for physician services in 1984 have been estimated at $15.3 billion.

BACKGROUND

Health Care Costs

Health care costs in this country, including the dollars for physician reimbursement, have been steadily increasing. In 1965, total health care expenditures were approximately $39 billion and represented 5.9% of the gross national product (GNP). In 1982, these figures had increased to approximately $321 billion, and the percentage of GNP for health expenditures was at approximately 10.5%. The Administration's projections indicate that total health care expenditures will exceed $750 billion by 1990, and this will account for approximately 12% of the GNP.

There has been a great deal of concern expressed about the growth of health care expenditures in this country. It is important to point out, however, that the United States is in no way unique in the amount of resources allocated to health care. Available data show that the average annual rate of increase for health care expenditures experienced in the United States was less than that seen in many western nations. The average annual rate of increase for total health care expenditures in the United States from 1969 to 1976 was 12.5%. However, this figure was higher in Australia (20.5%), Finland (18.9%), the Netherlands (18.4%), the United Kingdom (18.2%), West Germany (17.7%), France (16.5%), Sweden (14.6%), and Canada (14.3%). In addition, the analysis of national health expenditures in these nine countries indicates that the percentage share of GNP for health care expenditures in the United States is not out of line with that of the other countries. While the share of GNP in the United States was 8.7% in 1976, Netherlands, West Germany, France, and Sweden all had percentage expenditures greater than 8.2%; Australia, Finland, and Canada all had expenditures greater than 7%; and only the United Kingdom had an expenditure that was less than 6%. We point out these national health care expenditure figures for other countries to show that the United States is not alone in recognizing the importance of health care for its citizens.

Health care costs are not immune to outside market forces. A significant percentage of health care cost increases is attributable directly to the severe inflation that has beset our economy. As a matter of fact, the element contributing the most to the growth in expenditures for health care from the period 1971 to 1981 has been the general inflation affecting the economy. According to an article published in the March 1983 issue of Health Care Financing Review, general inflation "accounted for approximately 57% of the increase in total systems costs (personal health care costs) for the period 1971 to 1981." In addition, approximately 8% of the growth in expenditures is directly attributable to the aggregate population growth over that period of time.

A review of health care costs in this country cannot be divorced from the fact that the mix of services available involves more sophisticated technology that is being continually updated. Technological advances have served to improve the overall quality of health care that is available, and they have also served to increase the overall cost of health care services.

An additional reason for increased health care expenditures, including physician reimbursement, is the aging of our population. Health care expenditures and the federal responsibility for health care coverage through Medicare will increase over time as the population and elderly population in particular increases. Between 1983 and 2025, the total population is projected to grow by almost 30 percent, with the elderly population doubling to a total of 58 million or 19.4 percent of the total population. Among the elderly, the group over age 75 will also experience substantial growth: 40 percent of the elderly are now older than age 75, and this figure will increase to 45 percent in 2025; and the over age 85 group will triple from the current 2.5 million people to 7.6 million people in 2025. This substantial increase in the elderly population is particularly important as the elderly have historically utilized a greater proportion of health care resources.

In 1978, the average per capita expenditure for health care by Medicare-eligible individuals was $2,026. The significance of this figure is illustrated by the fact that average per capita spending for individuals between the ages of 19 and 64 totalled $764, and for individuals under age 19 the figure was $286. The statistics also indicate that individuals over the age of 65 are more likely to be hospitalized than those under that age, they use more hospital days per hospitalization, and they visit their physician and other health care practitioners more frequently. The importance of these figures is clear: as the population ages, demands for health care services correspondingly increase and the total cost for providing those services increase.

The AMA does recognize that some health care services should be examined for their cost-effectiveness. We have been taking positive actions to review the delivery of health care services and to eliminate those health care costs that are inappropriate and that are not benefiting the public. (Attached to this statement is an appendix indicating AMA activities to promote the cost-effective delivery of all health care services.)

Physician Reimbursement and Beneficiary Liability

An important factor that has enabled physicians to treat their Medicare patients in the same manner as other patients is that there is no need for a physician to differentiate between patients who are Medicare beneficiaries and other patients when it is time to submit bills for services. According to a 1979 General Accounting Office (GAO) report, physicians usually charge Medicare patients the same as other patients. However, the report goes on to indicate that physicians are generally allowed less for similar procedures under the Medicare program.

The American Medical Association fully recognizes that a central issue before the Committee today is the amount of personal liability individual Medicare recipients experience when faced with a physicians' bill for services. First of all, a substantial portion of individual liability is directly related to the mandated deductible and coinsurance requirement — an amount often paid by private supplemental (Medigap) insurance. Also, only a portion of liability is directly related to physician charges that are above the Medicare allowed amount. Furthermore, beneficiary liability beyond coinsurance and deductible responsibility is generally not substantial. The following facts must be kept in mind:

- physician charges to Medicare beneficiaries are in harmony with charges to non-Medicare beneficiaries;
- The application of the economic index has served to arbitrarily increase beneficiary liability;
- Approximately two-thirds of all elderly Medicare beneficiaries have some form of Medigap coverage;
- The fixing of the beneficiary deductible at $60 from 1973 through 1981 has largely been responsible for decreasing the total portion of beneficiary payments for deductibles and coinsurance from 32.3% of total expenditures for physician services in 1968 to only 20.8% of beneficiary responsibility for these expenditures; and
- Approximately 78% of the aged population in 1978 who received Medicare payments for physician services experienced some liability exceeding the deductible and coinsurance amounts for unassigned claims, with only about 15% of this population having liability of $100 or more.

Determining Physician Reimbursement Under Medicare

Medicare reimbursement steadily has been diminished over time with various changes authorized by Congress to reduce program expenditures. For example, there has been a substantial reduction in reimbursement brought about by the application of the economic index in fiscal year 1976.

The economic index has caused and continues to reduce Medicare reimbursement for physician services in comparison with other payment mechanisms as it uses the prevailing charge level in effect on June 30, 1973 (which by virtue of a statutory time lag reflects 1971 actual charges) as the base year figure for setting the index. The index is also based on statistical data that fail to reflect actual increases in the costs of providing medical services.

Since the initial application of the economic index, the AMA has consistently pointed out that its limiting effects have been a significant reason why physician charges have in many instances exceeded the Medicare-allowed level. The economic index has served to almost double the percent of "general practitioners" who had customary charges exceeding the prevailing charge limit for office visits, according to an Urban Institute study conducted pursuant to a grant from the Health Care Financing Administration (HCFA) in 1981. If the economic index had not been in place and the prevailing charge was allowed to rise to reflect normal charges, only 25% of the practitioners would have exceeded the prevailing charge level in 1978, and this figure would have actually decreased to approximately 23% in 1980. With the arbitrary limits of the economic index in place, 43% of the general practitioners in the study group had customary charges that exceeded the prevailing charge for limited office examination visits in 1978, and this figure rose to over 46% in 1980. Directly as a result of the existence and application of the economic index, nearly an additional 20% of the "general practitioners" in the study group exceeded the prevailing charge level in 1978 and an approximately additional 25% exceeded this level in 1980. According to the study, general surgeons, internists, orthopaedic surgeons, and ophthalmologists had similar patterns for office visits.

PHYSICIAN REIMBURSEMENT OPTIONS UNDER MEDICARE

There have been many proposals in recent years to modify physician reimbursement under the Medicare program. The AMA has reviewed these proposals, and we will discuss our concerns about some of them.

Freeze in Physician Reimbursement

On March 7, the American Medical Association sent a letter to every physician in the country urging each to voluntarily freeze his or her fees for a one-year period and to continue to take into account the financial circumstances of each patient -- especially the unemployed, the uninsured, and those under Medicare -- and to accept reduced fees when warranted. In a November 1, 1983 letter to all members of the House of Representatives, the AMA has pledged to ask physicians to refrain from passing additional costs to their elderly patients, and to urge all physicians to be considerate of the needs of their patients and to avoid increasing the financial burdens of their patients.

In calling for an across-the-board freeze of physician fees, the AMA is asking physicians to contribute to a resolution of the economic problems facing our health care system. While all of the segments of the health care system have contributed to the increases in health care costs, physicians are now going to take a positive step to arrest this trend through the voluntary one year freeze in their fees. With the overall economy as a whole in far better shape today than it was even one year ago and with inflation no longer continuing to grow annually in double digits, the AMA believes that a vast majority of physicians will heed the call to voluntarily freeze their fees.

The voluntary freeze proposed by the AMA applies to all physicians and includes charges to physicians' patients that are covered by Medicare. We also believe that this step will be especially helpful in easing the current deficit problems facing the federal government, as the action taken by the AMA is in line with a one-year freeze of Medicare payments to physicians as proposed by the President in his recent budget.

Mandated Assignment for Physician Services

In our opinion, the current system where physicians have the option to accept assignment on a claim-by-claim basis has been used properly, and it should be allowed to continue. Of the nearly 90% of physicians that treated some Medicare patients in 1982, approximately 70% of those physicians accepted some claims on an assigned basis. Also, the percent of physicians who do accept some assigned claims has actually increased from over 61% in 1978 to the approximate 70% figure in 1982. The Medicare program has allowed physicians who do not accept assignment on all claims to charge patients in addition to the Medicare "reasonable charge" in recognition of the facts that the Medicare program is not intended to be a welfare program; that it fails to reimburse physicians at the usual, customary or reasonable charge; and that the reimbursement mechanism should encourage physicians to participate in the program. In the development of the Medicare program, Congress considered these matters in giving physicians the option to bill directly or accept an assignment.

Because physicians have a choice to accept or not accept assignment, Medicare beneficiaries are in turn able to select a physician from virtually the entire physician population. A change in the assignment policy, especially in light of proposals to further hold down Medicare Part B reimbursement, could affect the access of Medicare patients to the physician of their choice. Indeed, a paper prepared pursuant to a grant from HCFA and published in the Summer 1983 issue of Health Care Financing Review indicates that if physicians were placed in a position of having to decide whether to accept all or none of their Medicare patients on an assigned basis that over two-thirds of physicians would take no assignments. This would result in a drastic reduction in assignment rates nationwide.

Physicians consider a number of factors in deciding whether or not to accept assignment on a particular claim: the nature and expense of the service provided, past payment experience with the Medicare carrier, the ability of the individual patient to pay for care on a par with non-Medicare beneficiaries, and the relationship between the physician and the patient. This last factor is particularly important, as it raises the point that patients should discuss whether they (patients) have a need for the claim to be submitted on an assigned basis prior to the initiation of the billing process. Statistics clearly point out the fact that most physicians are willing to accept assignment of some claims.

Examples of charges substantially higher than the Medicare recognized charge are the exception and not the rule. Indeed, physicians treat many Medicare beneficiaries at a reimbursement level that is significantly below the usual and customary level of reimbursement. The following statistics for 1979 (generated by HCFA) detail the record of physician acceptance of Medicare assignment.

In 1979, 51.1% of all claims (aged and disabled beneficiaries) were assigned, and 50.7% of the total charges were assigned. Breaking these statistics down further, assignment rates increase in situations where average annual charges per user increase. While the percent of total charges that were assigned for aged Medicare enrollees equalled 46.5%, this figure steadily increases as total annual charges per user increases.

Total Annual Charges Per User	Assigned Charges As A Percent Of Total Charges
$1-99	29.5%
100-149	28.8%
150-199	32.5%
200-249	34.6%
250-299	36.2%
300-349	38.0%
350-399	40.0%
400-499	41.6%
500-699	44.4%
700-999	46.1%
1000-1499	46.6%
1500-1999	46.2%
2000-2499	48.5%
2500-and up	54.3%

The percent of services assigned and the percent of total charges assigned similarly increase as beneficiaries grow older. This is particularly significant as Medicare reimbursement for physician and other medical services increases with age.

Age	Reimbursements Per Enrollee	Percent of Services Assigned	Percent of Total Charges Assigned
65-69	$187	43.7%	44.4%
70-74	$213	44.6%	45.5%
75-79	$241	47.3%	47.9%
80-84	$253	51.0%	51.2%
85 and up	$260	59.4%	59.2%
Average Total	$219	47.9%	48.3%

Responsibility for charges in situations where physicians do not accept assignment under Part B rests with beneficiaries. While individual examples can be pointed out about beneficiaries with large outstanding liabilities for services, the statistics clearly illustrate that most individual beneficiaries are not being faced with high levels of personal liability for physician charges.

While it is reasonable to expect that the great percentage of Medicare beneficiaries have some unassigned claims (78%), the personal liability exceeding the deductible and coinsurance amounts for 83.9% of Part B service users was less than $100 on unassigned claims. It should also be noted that total user liability for Part B services includes mandated co-insurance and the Part B deductible ($60.00 in 1979). For those individuals who used Part B services in 1979, 64.9% of them had a total user liability of less than $150 each. The following chart sets out total user liability for individuals receiving Part B services in 1979.

Amount of Total User Liability*	Average Co-Insurance Liability**	Total Percent of Those Submitting Claims	Average Reimbursement
$0-50	$11	16.6%	$44
$51-75	$14	15.5%	$57
$76-100	$24	15.3%	$95
$101-150	$45	17.6%	$178
$151-200	$78	8.9%	$311
$201-250	$112	5.6%	$447
$251-300	$145	3.7%	$579
$301-400	$191	5.0%	$762
$401-600	$270	5.4%	$1079
$601-and up	$514	6.4%	$2055

*Including co-insurance and $60 deductible.
**These figures are based on the assumption that average reimbursement is 80% of the Medicare recognized charge.

The American Medical Association believes that the figures set out above show that the medical profession has an exemplary history of treating Medicare beneficiaries on an assignment basis. In addition, Medicare fees for physician services have been subjected to arbitrary reductions through prevailing fee limitations and the application of the economic index.

The existing system where physicians have an option to accept or not accept assignment has not resulted in beneficiaries facing substantial out-of-pocket costs as a result of physician charges above the Medicare recognized "reasonable" charge. Indeed, the fact that over 50% of all claims are assigned and that over 50% of the total charges were on an assigned basis in 1979 points to the fact that case-by-case determinations on the acceptance of assignment allows assignment decisions to be molded to fit the individual situation. Furthermore, the figures for acceptance of assignment have been steadily increasing: in 1982, 52.8% of all claims were on an assigned basis, and 54.2% of total charges were assigned.

Participating Physicians

Another proposal relating to acceptance of Medicare assignment that has been under discussion is the "participating physician" concept. Under this type of proposal, physicians who agree to accept assignment on all claims for Medicare beneficiaries will be listed as "participating physicians," and other physicians could still be allowed to participate in the program and make assignment decisions on a claim-by-claim basis. Various versions of this concept have been discussed including different levels of reimbursement for participating and non-participating physicians. While such proposals may be attractive on their face, they pose numerous problems. First, the elderly would be given the mistaken impression that only physicians indicated on the list as "participating physicians" would be eligible to provide service for Medicare beneficiaries. It also fails to recognize situations where physicians may accept assignment for a substantial percentage of their Medicare case load while continuing to bill their full charge to those patients in their practice who can afford to pay the full charge.

The fact that the participating physician concept provides Medicare beneficiaries with assignment information on only the percentage of the physician population that will accept assignment in all cases leads us to conclude that this proposal will not result in an overall increase in the assignment rate. Differential reimbursement levels for participating and non-participating physicians ultimately could penalize the beneficiary. The American Medical Association does not believe that a participating physician program should be instituted: the current level of acceptance of assignment appears to be appropriate given the general amount of beneficiary liability for unassigned claims; developing a participating physician program would be administratively complex and expensive; and such a program would offer only minimal benefits.

Reimbursement Incentives

One of the problems with the Medicare program is the paperwork requirement associated with it. To correct this problem, we recommend a series of administrative modifications to the physician billing and payment process that could eliminate some of the paperwork burden. In addition, we believe that billing initiatives could also serve to encourage even greater physician participation in the Medicare program. Some billing initiatives that could be undertaken on an administrative level include:

> Multiple-List Claims. Currently, claims must be submitted to Medicare on the basis of one claim for every office visit. If the claims process could be modified to allow for a single claim to account for all services to a patient in a specific time period or to account for services to more than one patient, the paperwork burden could be substantially reduced. This could also lead to fewer claims being processed and administrative savings.
>
> Automated Billing. The technology exists to allow for claims to be electronically submitted and paid. This type of electronic billing and payment procedure would also decrease administrative costs of the program and it would work to increase physician participation by speeding cash flow for Medicare patients.
>
> Periodic Payments. Where Medicare beneficiaries constitute a substantial portion of a physician's practice, a system could be developed where payments accepted on an assigned basis could be made to the physician on a periodic basis in a lump sum based on estimates of the services to be provided over that period of time. While this system would require continual adjustments in such payments, it would act as a substantial incentive for physicians to treat Medicare beneficiaries and accept assignment through its assurance of continual cash flow.

Physician Payments Based on Diagnosis Related Groups (DRG)

Another concept for physician reimbursement that has been discussed is to base payment for physician services on DRGs. This concept is to be the focus of a Congressionally-mandated study from the Department of Health and Human Services (HHS) that is due in December 1985. Pending the outcome of such a study, we believe it premature to consider this modification in physician payment. In addition, we are concerned that such a radical restructuring in payment could be imposed without even limited experiments with such a system. Minimally, demonstration projects with this concept should be conducted to give insight into its very feasibility.

Just as the AMA has concerns over the hospital DRG payment program, we have concerns with a DRG-based physician payment plan. Even if such a plan was feasible, we have grave questions over how it could impact on the quality of care. While we do not expect that physicians would consciously limit the care they provide, a DRG system would give substantial economic incentives to provide minimal care. The DRG methodology of payment also concerns us because of its failure to take into account severity of illness. This fact could be especially troublesome for those physicians who, because of their specialized skill and training, see patients with the most severe illnesses.

We are particularly concerned about a program where all services to hospital inpatients could be based on DRGs and made through the hospital. First of all, physicians with privileges at only one hospital would be at the mercy of the hosptal for their reimbursement, and the institution could penalize physicians by providing minimal payments in cases that exceed the average length of stay for any particular DRG. Also, if both hospital and physician reimbursement is based on a predetermined amount, the physician has an economic disincentive to act as the guarantor of high quality health care.

The AMA cannot recommend a reimbursement change based on DRGs without any showing that such a change would be feasible and not detrimental to the quality of health care services.

Long-Term Restructuring of Physician Reimbursement Under Medicare

The American Medical Association recognizes that the Medicare program and the Part A program in particular are heading for a fiscal crisis in the next decade. Accordingly, the AMA Board of Trustees has directed two of its councils, the Council on Legislation and the Council on Medical Service, to develop a program that would help assure the long-term solvency of the Medicare trust fund. In this review of the Medicare program, no aspect is being held sacred and we fully expect to examine the methodology of payment for physician services.

Physician reimbursement methods generally have been the subject of continuing study by the AMA, and further recommendations on this subject will be considered at the Association's June meeting. At this time, the Association maintains that the usual, customary and reasonable methodology for determining payment for physician services should be viewed as just one mechanism to assure payment for services, and that experiments should be conducted on alternative methods such as voluntary vouchers to pay for health care services, including physicians' services. The Association is also examining potential program changes that could result in having more physicians accept the Medicare reimbursement as payment in full for all lower income beneficiaries.

CONCLUSION

The American Medical Association is committed to the provision of the highest possible quality of care for Medicare beneficiaries. To assure the viability of this commitment into the future, the AMA is now midway through the process of reviewing the Medicare program with an eye toward assuring its very existence into the next decade. The AMA is proud of the role physicians have played in treating the millions of Medicare beneficiaries over the last eighteen years. We firmly believe that these beneficiaries generally have received high quality services from physicians at appropriate costs. We fully expect that this record will continue into the future.

COST-EFFECTIVENESS ACTIVITIES OF THE AMERICAN MEDICAL ASSOCIATION

National Commission on the Cost of Medical Care

The American Medical Association has taken an active role in issues relating to the cost of health care. The AMA was instrumental in the development and operation of the National Commission on the Cost of Medical Care, and has been working to implement recommendations from this Commission relating to strengthening price consciousness, private sector cost containment initiatives, working through the regulatory process, cost containment measures within medical practice, issues relating to supply and distribution of health care providers, research guidelines, and consumer and patient information. An important element of this Commission's report emphasized the importance of changing incentives within the health care delivery system to enhance competition. The 48 recommendations of the Commission on the Cost of Medical Care, issued in 1978, have served as a starting point for AMA activity related to cost-effectiveness.

Cost-Effectiveness Publications

For the past four years, the AMA has published an annual Cost Effectiveness Plan. The 1984 Plan documents the Association's on-going efforts to stem inappropriate growth of medical care costs. This Plan details numerous activities of the AMA to meet its commitments concerning limiting health care costs that are found to be inappropriate.

The American Medical Association fully recognizes that an important element in the growth of cost effectiveness activities is the publication of information about on-going efforts to deliver cost effective health care. To this end, the AMA is in its third year of publishing the AMA Cost Effectiveness Bulletin. This Bulletin is designed to provide cost effectiveness information to state medical associations, metropolitan and county medical societies, and national medical specialty societies. In addition, this Bulletin is generally available to hospitals, hospital associations, and other interested parties. The Bulletin publicizes information on AMA cost effectiveness activities and also publishes information related to the activities of other organized groups working to this end.

Cost-Effectiveness Network

One of the more promising activities that the AMA is involved in concerning cost effectiveness is the recently formulated cost effectiveness network. This network is sponsored by the AMA in cooperation with the American Hospital Association and the Federation of American Hospitals. It is aimed at involving hospital medical staff and administrators in collaborative cost effectiveness activities. The program consists of more than 85 hospitals throughout the country that will take part in experiments to evaluate a variety of cost effectiveness projects.

The first project implemented within this network was a protocol for holding economic grand rounds. (An implementation guide for economic grand rounds has been published and is generally available.) The purpose of this program was to enhance physician awareness of the cost of the services they order by use of the grand rounds teaching forum. This program had essentially four operational goals:

- to encourage practicing physicians to reflect on their practice patterns in the context of cost effectiveness issues;
- to reinforce clinical behavior which is directed toward the cost effective delivery of high quality medical care;
- to change physician behavior where appropriate to reflect more cost effective delivery of high quality care;
- to stimulate additional subsequent activities geared to foster the cost effective delivery of medical care.

As this program and other programs developed through the cost effectiveness network prove beneficial, it is hoped that similar programs can be launched in other hospitals and that a major impact will be felt throughout the health care delivery system. A new program that is now being analyzed through the cost effectiveness network is a study designed to improve the efficiency of the utilization of respiratory care services.

Health Care Coalitions

The AMA has recognized the fact that medicine by itself cannot act to hold down rising health care costs. For this reason, the AMA started working with state and county medical societies in 1979 in the development of community-based health care coalitions. These coalitions work to bring together physicians, business and labor representatives, hospital management, and insurors to provide local forums to seek ways to contain costs while maintaining accessibility and high standards of heath care.

Health care coalitions have had success in such diverse activities as case management and utilization review, expanding physician and employer knowledge about employee limitations in particular work places, redesigning corporate benefits to encourage more cost effective ways to use the health care delivery system, increasing opportunities to develop the most cost effective and equitable forms of provider payments, drafting and supporting legislation to reform medical liability laws, developing health education programs in the workplace, collecting and analyzing data on the utilization of services, and community health planning.

Conferences on Costs

The AMA has undertaken other activities to emphasize the importance of cost effectiveness. In 1982, the AMA cosponsored the National Conference on Utilization of Health Services with the American Hospital Association and the Blue Cross and Blue Shield Associations. This program focused on improving the efficient use of health services through early discharge programs, alternatives to inpatient care, and effective utilization review. Because of the success of this conference, the AMA has expanded its program on utilization of health services. The AMA also sponsors an annual conference, the National Medical Specialty Society Cost Effectiveness Conference, to aid medical specialty societies in the development of cost effectiveness projects that are geared to their own memberships.

Medical Education and Practice

The groundwork for cost effective medical practice must begin in medical school. To this end, a recommendation from the National Commission on the Cost of Medical Care was that medical, dental and osteopathic schools should expose students to the economics of the care they deliver. Since this recommendation was adopted by the AMA House of Delegates in 1978, most medical schools have integrated cost containment as an element of medical education. As of 1981, the subject of cost containment was taught in 93 of the 124 United States medical schools, and the issue was taught in almost every state.

In addition to stressing the value of cost effectiveness in medical education, the AMA is also stressing the value of prevention in all aspects of medical care as a means to achieve cost effective health care delivery in this country. Aside from organized activities geared toward curtailing health care costs, the single most important means by which American physicians work to hold the line on health care costs is in the development of a physician/patient relationship. Through this relationship, physicians work to promote healthier life styles and to educate their patients to prevent disease and injury from occurring. Physicians have been leaders in anti-smoking campaigns and in educating the public on issues such as moderation in the use of alcohol, the use of child passenger restraints in automobiles, and drug abuse.

Health Policy Agenda

The American Medical Association realizes that Congress needs assistance from the public in making any future determinations on how health care services should be delivered in this country in the future. To this end, the American Medical Association has taken the first step by initiating a project to create a future health policy agenda for the American people. This project is designed to develop a philosophical and conceptual framework as the basis for specific action plans and proposals that are to be responsive to the particular social, economic, scientific, educational and political circumstances facing health care decisions. To develop a series of policy principles and action plans, six work groups have been organized to develop policy principles and action plans in the following areas: medical science; health professions education; health resources; health care delivery mechanisms; evaluation, assessment and control; and payment for health care services. The AMA expects that the Health Policy Agenda project will look to the cost of providing health care services.

The first phase of this project, the development of principles, is now nearing completion, and the work groups are now in the process of identifying issues as the next step to developing action plans to carry out the principles. This activity involves approximately 150 organizations including representatives of medicine, government, nursing, labor, business, the hospital industry, the public, and health care insurors. By this broadbased organizational body, we hope to be able to present Congress with viable principles and working programs for the development of a future health policy agenda that will assure the availability of high quality health care services for the American people.

Chairman HEINZ. Professor Rice.

STATEMENT OF THOMAS H. RICE, PH. D., CHAPEL HILL, N.C., ASSISTANT PROFESSOR, DEPARTMENT OF HEALTH POLICY AND ADMINISTRATION, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF NORTH CAROLINA

Dr. RICE. Thank you. Mr. Chairman and members of the committee, my name is Thomas Rice. I am an assistant professor in the department of health policy and administration, school of public health, University of North Carolina at Chapel Hill. The opinions and conclusions that I express today are my own alone; they do not reflect those of the University of North Carolina or the National Center for Health Services Research—NCHSR.

From my research over the past 5 years, I have concluded that the Federal Government cannot control the cost of the medicare program by freezing physicians' reimbursement. This procedure is not effective because physicians respond by billing the program for a greater number of services, and for more complex and costly services. By billing medicare for these additional services, physicians are able to recoup the income they might have lost by the freezing of reimbursement rates.

I have reached this conclusion as a result of my own research and from the research of other health economists. In my research, which was funded by NCHSR, I examined how physicians in Denver, Colo., responded when their medicare reimbursement rates declined in 1977. I found that in response to these lower payments, physicians billed medicare for a greater number of services, for more complex office and hospital services, and ordered a greater number of laboratory tests. Furthermore, the physicians were less willing to accept medicare patients on assignment.

Similar evidence has been collected by John Holahan and William Scanlon, researchers at the Urban Institute, who examined responses of California physicians to price controls during the early 1970's. They found that medicare payments for these physicians continued to rise as quickly during price controls as they did prior to the institution of price controls. This was true because physicians billed the program for a greater number of services and for more complex services. These same researchers, in conjunction with Margaret Sulvetta, also found that a freeze in medicaid program reimbursements to California physicians did not control physician payments under that program during the mid-1970's, for the same reasons.

Although I have only mentioned two studies, another health economist and I, John Gabel, from National Health Services Research, recently conducted a review of all other studies of this type, all of which reached similar conclusions: under current fee for service reimbursement schemes, the Government fee controls are not successful in controlling total physician payments. Although these studies were conducted several years ago, they provide the only available information on physician behavior resulting from changes in reimbursement rates.

I would now like to briefly discuss another topic that is being considered by your committee, making assignment mandatory.

I do not favor across-the-board mandatory assignment at the present time because it may jeopardize access to physician services by the elderly and disabled. I have reached this conclusion by examining the medicaid experience. The medicaid program, as you know, sets physician fees, often at very low levels. Studies of medicaid programs show that many, if not most, medicaid recipients have difficulty obtaining access to physicians who are willing to accept the medicaid fee. Mandatory assignment under medicare could create similar access problems for medicare population, especially if reimbursements are frozen.

I would favor one of two less drastic alternatives: Either requiring assignment for inpatient services, or requiring assignment for services in which medicare patients comprise the majority of the market, such as cataract operations. This latter alternative has been suggested by Frank Sloan at Vanderbilt University.

The former alternative, mandatory assignments for all inpatient services, is especially attractive for a number of reasons. First, it will provide physicians with a strong incentive to deliver services in outpatient settings, which are much cheaper than inpatient settings. Second, it will shield beneficiaries from the large liabilities associated with nonassigned inpatient services, especially surgery. Third, because medicare patients comprise a large portion of total hospital patients, it is unlikely that physicians will be able to refuse treatment without losing much of their practice income.

In summary, I think mandatory assignment for inpatient services could mildly reduce Government costs by providing physicians with an incentive to provide outpatient services, could also reduce patient costs, and might not significantly impair access to care.

To conclude, I think that it will be difficult if not impossible for the Government to control physician costs under the current fee-for-service reimbursement system. Although medicare can set its price by freezing prevailing charge levels, physicians still will control the quantity and mix of services provided, and thus, effectively control the total cost of services. It might be possible to modify the system to give physicians a financial incentive to provide more outpatient services. However, I think that meaningful cost control can only come about through a major change in the financing or delivery system for physician services. Congress has already made such a change in part A of medicare by adopting prospective payment—the DRG system. In my opinion, changes of a similar magnitude are needed to control physician costs under part B.

Thank you.

Chairman HEINZ. Thank you very much.

Let me ask Vita Ostrander and Bill Hutton. You have been talking about a lot of proposals to change present policy, but one of the first things that we might ask ourselves is whether we are doing enough to make present policy work. One of the suggestions is not a new one, but it was reinforced today by Professor Reinhardt, was that there ought to be a mechanism of getting more information to the elderly about what physicians accept assignment and the idea of a hot line, for example, was mentioned. What is practical? What can we do to give the elderly more information so they can go to a doctor that agrees not to go above the limitations?

Vita, do you want to answer first, and then Bill.

Ms. **Ostrander**. I'd like to respond in terms of the current effort that has been made by HCFA to public assignment lists. There is a problem with that, using that as a vehicle to inform the elderly. The lists are done statewide. They are alphabetical, with percentages.

We have to recognize the makeup of our country. It is not all urban. It is rural in many areas. And many of the elderly will be just confused in trying to use those lists. Unless we can break it down by specialties and locations in States, those lists again will not mean very much.

Chairman **Heinz**. So all we need is a cross-indexing system, which in this day and age of computers should be just about the easiest thing to do in the world.

Ms. **Ostrander**. Well, that would be fine. But you also have to consider the age of this segment of the population that is growing the fastest. You must keep it simple, because when the frail elderly are asked to use these systems, we don't want to create confusion for them.

We have listed flat percentages on lists. But we don't ask how those percentages are derived. And I think that must be explained a little bit better. There should also be at least some form of narrative which explains to the beneficiary what it means to have the physician accept assignment to that beneficiary. I think that is still a very cloudy issue for very many of the elderly who do not understand the benefits.

I think it's been stated right from this panel that some of the elderly find it difficult to ask a doctor to accept assignment. You have got to put that right up front.

One of the other problems we will list is it shows group practice rates. That does not define what the individual doctors in the group practice area individually accept. I may go to a group that I like very much, but the doctor that I go to may not accept very many assignments of medicare. I think that must become easier to understand. I believe that if we do an improvement over the materials that we put out on the assignment issue, this will contribute a great deal for the elderly.

Chairman **Heinz**. Bill, do you have any comments?

Mr. **Hutton**. Yes.

We have tried in various parts of the country. Some of our national council senior citizens affiliated groups have published their own directories of who accepts assignments. Some of these are good, and others find it very, very difficult to get information.

I think a hot line would be very useful if we can persuade the Department of HHS to get it done. It is very, very difficult to get information. It is also very complicated.

And the vision that you gave me a short time ago, "We can do it so easily by computer, you know." Our old people really don't have computers.

Chairman **Heinz**. We can get the lists.

Mr. **Hutton**. Well, I hope.

But it is very difficult when you have got so many different things to put in there, it is very difficult to even frame them what it means, when the doctor only takes assignment on certain conditions at certain times, Tuesday, Friday, and Saturdays, will accept assignments because then they are going out playing golf, they won't accept them other times.

Chairman HEINZ. That is probably why we need a computer, to keep track of people.

Mr. HUTTON. Well, anything that can be done to improve the idea of getting across to the elderly people who does and who does not and when, accept assignments. But I do not think the medical profession will cooperate in that, either. It will be very helpful if we get them to a doctor who does.

Chairman HEINZ. Let me ask you something: It has been suggested that we might set up what you would call a preferred provider organization arrangement, that is, a system where medicare would reward beneficiaries who seek out lower cost care. And the reward would be that there would be lower cost sharing. You find a doctor who charges less, and instead of coinsurance of 20 percent, it is something less, 15 percent, let's say.

And there is an incentive, therefore, for doctors to be low cost, because they will attract more medicare beneficiaries, and there is an incentive for medicare beneficiaries to shop for those doctors because they will not only be billed less but they will have a lower coinsurance.

What do you think of that idea?

Mr. HUTTON. I think that might be something to work out. Obviously, we have got to make some compromises here. And I do think we have a mix. Like Dr. Rice's comment, for example. There is no reason we should not make mandatory assignments for all inpatient stuff. All the doctors in the hospital, should accept assignment. That would save money. But it would also save older people from putting up much more money than they really have, a combination of that kind.

Ms. OSTRANDER. PPO's, there would be a wide variance about negotiated fees. And there are many problems that you could end up with. One of them, as I see it, being out in the field, is not all of our communities are urban. You have some rural areas. So you are not really addressing all of the facets of the problem.

So at this point, while we do need choices, I have some serious reservations, as does AARP, in terms of PPO's.

Chairman HEINZ. Well, let me ask Dr. Todd—I have got actually several questions. I am not going to ask them all because I want to yield to Senator Burdick for questions.

But Professor Rice has suggested that the voluntary freeze on fees and the voluntary agreement not to increase extra charges is not going to be effective because even if every single doctor in the country agrees to that, there is a compounding and usually successful drive to increase income somehow. And if you look at human nature, that is a pretty reasonable proposition.

If the AMA really wants to control costs, both to beneficiaries and to the Federal Government in order to stave off some other kind of less desirable policy choice, at least from your point of view, perhaps from the Nation's, why would you not ask your members not only to agree to the freeze on fees and the freeze on extras going to beneficiaries, but also to limit total medicare billings, as well, so we do not get the volume effect, not only the rate effect?

Dr. Todd. Well, there are several answers to that, Senator.

The first is that I do not accept the concept that physicians will increase services to the beneficiaries just because of some arbitrary limit placed on their ability to raise their fees. I think the average physician in this country, when faced with a fee freeze, will work harder, will see more patients, and will provide necessary care for those patients. And, indeed, in that regard there may be some benefit to a fee freeze.

The physicians may tend to work harder. They may tend to see more patients, and they may tend to work——

Chairman Heinz. That is suggesting they are not working hard enough now.

Dr. Todd. If you look up the statistics, they are working fairly hard.

Chairman Heinz. I am just taking your argument, I am not criticizing physicians.

Dr. Todd. I do not think there is any individual in this country that could not extend their activities a little farther if there were a need to or indication to.

In terms of your second comment about limiting total amount of billing that a physician or a profession would permit to the medicare beneficiaries, do not forget we are looking at a range in the total population increase of the amount of care that elderly people receive. Technology continues to develop, all of it in some degree benefitting some patients. And if you put an arbitrary cap——

Chairman Heinz. We are asking you to put a voluntary cap on it.

Dr. Todd. Still, how do you decide what is the appropriate cap? And how does the individual physician in his practice decide which care he will provide to which patient?

Chairman Heinz. Obviously, the point is that he does that now, and has got to do it in the future. And our concern—and it is a real concern based on what used to be called the Dow theory—is that what happened yesterday is most likely to happen tomorrow; even if your voluntary freeze is 100 percent successful, that many things are going to happen which will still cost beneficiaries and medicare the money we thought you were going to save us.

Now, that is called also Murphy's law, as well as the Dow theory. And my question is: What is wrong with you asking your physicians voluntarily to do what I just described, which is to do their best not to increase volume?

Certainly, if a housing complex for senior citizens opens next to some doctor's office, we now would expect him to increase his medicare billing, we would hope he would if he is a good physician. It has to be voluntary. But in the aggregate, it has to be voluntary to take those kinds of circumstances into effect. But what is wrong in principle with asking your profession to do what I have just described?

Dr. Todd. I do not think there is anything wrong in principle. I think it is untypical for a physician to provide services which are not necessary. And I have to conclude that any increase in services will be appropriately indicated.

Chairman Heinz. It assumes a kind of infinite elasticity of what's necessary. I understand your point; it is just hard to explain it to the public.

Dr. TODD. It is, indeed.

We have asked physicians to voluntarily freeze their fees. We have asked them not to pass on increased costs. And I think implicit in that is the request of the physician that he provide those services that are necessary. But as you pointed out, situations change, populations change, and it is absolutely impossible to know whether or not a physician who increases his volume is doing so out of an economic purpose, or because of changes in the demography of his practice.

Chairman HEINZ. One last point before I yield to Senator Burdick.

Would you put the first chart back up, Frank, the medicare part B supplementary medical insurance expenditures. I found this chart absolutely extraordinary. For the first 10 years, part B grows from a little over $2 billion to $2.8 billion. Granted, we had less inflation in those days, but then in the next 10 years, 1975 to 1985, it is projected to grow from $2.8 to $25.5 billion, no matter how you slice it, it is an absolutely staggering increase.

Physician fees are increasing this year when inflation is at the lowest rate in our history. This last year shows an increase of 16 percent, whereas the inflation rate increased 4 or 5 percent. If you would go back to the chart which shows how the payment for physician services is distributed, Frank—I want you to comment on this chart. I suggest that 16 percent of that rapid gross-increase that Vita Ostrander documented for us is being borne by the beneficiary contributions, directly by the beneficiary and not by Uncle Sam, not by the taxpayer, but by the members of the AARP, the members of the National Council of Senior Citizens, and all others who are not members of them, other Americans 65 and over.

What do we do about that?

Dr. TODD. Well, there are several responses to the figures you present. First of all, you are quite correct that inflation has eroded into the entire system. But over and above that, the incentives have changed and physicians are trying to do more and more in an outpatient setting and to keep patients out of the more expensive hospital areas, which in some areas is shifting costs from part A to part B.

If you look at the total percentages, the total percentage of that is made up in coinsurance, deductibles, and other insurance premiums. Only about 13 percent of that is due to physicians not accepting assignment.

Chairman HEINZ. Well, it is not entirely clear what the so-called medigap premiums really go to. Some of them may go to doctors to pay those extras.

Dr. TODD. The extras are generated partially by the fact that medicare reimbursement, partially because of the economic index, has not kept pace with the other reimbursement and charges in general.

Chairman HEINZ. Well, I do not want to overstay my time on this, but my point is that we have a problem, it is a real problem. And if you put those two charts up side by side, and if you are a senior citizen—you will be someday—you would say, "My goodness, this is how it is in 1975, how is it going to be in 1990, or 1995, the way those lines are going up and the way that nonyellow area is filling in." And you will be a bit nervous.

Dr. TODD. Indeed.

But in our testimony, we suggested that the total out-of-pocket responsibility for medicare beneficiaries in general was in the neighborhood of $100 to $150. It is also important to realize that not all of the elderly people in this country are impoverished. There are some very wealthy people.

I have had people come in and say, I can pay all the charges, and I want to do that as part of my responsibility. So physicians try in general to take into the account, the economic needs of their patients. And I think there is a reason why there is a variation of rates for physicians.

Chairman HEINZ. Informal means testing.

Senator Burdick.

Senator BURDICK. Thank you, Mr. Chairman.

Dr. Todd, did I understand you correctly that you do support the voluntary assignment?

Dr. TODD. We support a fee freeze, yes, sir.

Whether you want to call it voluntary assignment or not, I am not entirely sure.

I think we have asked the physicians in this country to hold fast to their fees at this particular point and not pass on additional costs over and above the medicare allowances to their elderly patients, who cannot afford them.

Senator BURDICK. Well, the members of your association, if they accept this assignment based on what HHS would send them as a list, would that be voluntary?

Dr. TODD. Beg your pardon?

Senator BURDICK. If they accepted the assignment figures issued by the Government, in their capacity, did they accept those assignments through the association?

Dr. TODD. Yes.

Senator BURDICK. I understand, then, it is the mandatory assignments that you——

Dr. TODD. We do, indeed.

We believe that would force patients and physicians to make very difficult choices. In addition, it would force the elderly to make a decision of whether they want to stay with the physician with whom they have long-term confidence or move to a physician who would accept the mandatory assignment.

Senator BURDICK. Getting back to voluntary assignment, would you object to information being disseminated indicating who might accept the assignments?

Dr. TODD. Not at all. We believe, indeed, in the saying that says an informed patient is our best patient. Physicians do not want unhappy patients. They want them understanding what the physician's responsibility is and what their responsibility is. And I would agree wholeheartedly that more information as to what the medicare program is expected to do and not expected to do, and particularly a listing of those pbysicians who are willing to accept assignment.

But bear in mind, there are those physicians who will accept assignment almost 100 percent for their needy patients, and almost 0 percent for those who have the ability to pay. And I think any such list should take that into consideration.

Senator **Burdick**. I understand that similar lists are coming out in April of this year, and I am pleased to hear that the profession will approve of that.

Dr. **Todd**. We have the intention of meeting with HHS to try and improve that list and make it easier for the elderly to understand and implement. We have no problem with the provision of the list as long as it is accurate and complete and understandable.

Senator **Burdick**. Getting back to the question I asked the first witness here today, to what extent, if you know, are there over-subscribed services in view of the possibility of malpractice suit?

To what extent does that exist?

Dr. **Todd**. Well, that is a hard figure to get at.

Because on some occasions so-called defensive medicine to one physician is good medicine to another physician. But I do not think you can deny the fact that there are things that are done because of threat of malpractice, and the fact that the courts seem to continually extend the liability of a physician even if a test has a very marginal value, and the physician has not obtained that test, and an unfortunate result occurs.

The physicians fear if they do end up in court, they are going to lose on that basis. There is no question. There is also no question that over and above the contribution of malpractice premiums, which are substantial, it adds a great deal to the cost of health care.

Senator **Burdick**. The witness that appeared here first suggested that perhaps there is some thought of a commission established or some board in lieu of a lawsuit in the courts, much like we have workmen's compensation.

Does your association think—what does your association think of something like that?

Dr. **Todd**. That is a very difficult issue to cover. Because if you are looking at compensation boards for workmen's compensation, automobile insurance, and whatnot, you have a very definable event which can be placed. Not every patient going into a hospital comes out better for that experience, but it is not always the result of the physician's activity.

It may well be the limitation of medical sciences, the condition in which the patient entered the hospital. So any sort of a mediation, arbitration, or hearing panel, is going to have great difficulties in determining which cases should be heard and which ones of those may well indeed represent negligence.

And you really come down to the issue of, do you wish to compensate every event in which negligence was involved or not, or whether you are going to try to sort out the negligence from the untoward event. In most of the doctor-owned insurance companies, somewhere between 40 and 50 percent of the claims presented to the company after careful investigation, have no basis in merit whatsoever.

Senator **Burdick**. Does the association have any suggestions other than the cold, hard lawsuit in district courts?

Dr. **Todd**. Well, we have lots of suggestions.

There is no question that physicians can do things. Happy patients do not sue doctors. We are well aware of that. We need to know what it is that keeps the patients happy and how to get physicians to do that.

But more importantly, we need to get physicians to look at the risk and involvement of various things that they do to patients, and to make sure that the patient understands the implications of these risks before proceeding with that procedure.

I do not think the solution is going to come from within the profession. I do not think it is going to come from within the Government, necessarily. I think it is going to be a combination of professional changes, a change in societal attitude, and certainly a change in the tendency of the judicial system to expand liability infinitely, not only in medical malpractice, but product liability, and in every other thing.

Senator BURDICK. Thank you very much.

Chairman HEINZ. Senator Burdick, thank you.

A couple more questions.

Dr. Todd, you in your testimony opposed a medicare participating physician program which physicians who agree in advance to take assignment for all medicare service would receive certain advantages.

I am told that Blue Shield offers such an arrangements, and that 80 to 85 percent of physicians have signed up with that. And that leads me to believe that physicians are not generally opposed to the concept of fixed predetermined fees.

So why do physicians oppose medicare, physician-participating programs if they accept it from other payors?

Dr. TODD. Well, you have to go back and look up the history of the Blues program. Remember, they were initially started by physicians to try to participate in health care costs way back when. The participating, nonparticipating, aspects of the Blues has diminished in past years, of reducing the basic rates and charging average charges regardless of the patient's ability to pay.

When it comes to medicare patients, we believe that the participating, nonparticipating concept would be very confusing. How do we make clear to the elderly that a participating physician accepts certain charges and a nonparticipating physician may accept those same allowances for that particular?

Elderly patients who have long-standing relationships with doctors suddenly see them in the nonparticipating columns and say, gee, I cannot go to my doctor anymore.

Chairman HEINZ. Maybe what should change is the wording so it is clear.

Dr. TODD. We think that would be a very difficult thing to do.

Chairman HEINZ. Change the wording?

Dr. TODD. To make it understandable to the average patient, particularly of——

Chairman HEINZ. Let me interrupt you at this point.

Now, we have got a couple of representatives. You are saying that the elderly will have difficulty understanding this concept.

Vita and Bill, is he right?

Mr. HUTTON. No.

Chairman HEINZ. Vita, what do you think?

Ms. **Ostrander.** Well, I think that we must not sell all the elderly short on understanding some of the processes. I keep hearing some of the same things over and over again, and it is evidence where the AMA would like to have us direct the program.

And I have got problems.

Chairman **Heinz.** Problems with his statement that the elderly are going to get too confused by this?

It does smack a little bit of stereotyping.

Ms. **Ostrander.** Yes.

We have to be concerned—I mentioned that myself—as we get up in years and that group grows, we have to make things simpler for them to deal with. But that does not mean that we should use the same stereotyping across the board.

That is not what the elderly are like.

In other words, it is the same concept that when I reach 65 I dropped off the cliff, and was no longer able to make a decision for myself.

Mr. **Hutton.** Mr. Chairman, just to add a line here, too many of the suggestions which come out on the subject of directories, even in PPO's, while helpful, they put the burden on the beneficiary. Now, we need a medicare payment policy which places the qreater burden on the providers and assumes beneficiaries will, the best they can, act as wise consumers.

Now, the second thing I would like to correct in Dr. Todd's testimony, which he referred to, is medicare policies. I want you to understand, Senator Heinz, that private insurance pays only about 12 percent of the elderly's health care bills. So medicare, medigap, does not really mean too much. And if there is one thing in this country which is inflated more than doctors' fees, it is insurance premiums to meet those. That is the only other thing which has gone up higher, staggering for older people.

And the fact is, in any event, insurance does not pay the unassigned charge for many older people.

Dr. **Todd.** Senator, could I respond just briefly?

I want to respond to Ms. Ostrander's comment about the list of those who would accept assignment as being difficult to understand, and we look back as a profession to a previous list coming out of HEW which had physicians that were dead still listed.

Chairman **Heinz.** Sounds like the Philadelphia voters' list.

Dr. **Todd.** The other point Mr. Hutton makes is, yes, indeed, this country needs a health care policy of some sort where we decide how we are going to allocate our resources and how we will provide for this appropriately, for those that need help.

And you should be aware that the American Medical Association has engaged in a 3-year project involving people from every segment of society, the Government, the insurers, the retired, the elderly, education, and the like. We try to develop some sort of rational health policy agenda which will be benchmarks by which we can make rational decisions.

We are in the middle of this program. It is a very exciting one. It may be a very promising one. And we have hopes that it will respond to some of the issues you now are wrestling with.

Chairman **Heinz.** Let's talk about mandatory assignment for a minute. You said, as I understood your testimony—please correct me if I understood it wrong, that two-thirds of the doctors would simply drop out of providing services to medicare beneficiaries if the program required assignment.

Dr. TODD. That's from HCFA.

Chairman HEINZ. Now, we have a couple of experts here. Dr. Rice has said that that is extremely unlikely. He has proposed a method of making it, as I understand, almost totally impossible. He suggested that there be assignment for inpatient services, an alternative which is a partial mandatory assignment. But Professor Reinhardt said he believed even across the board that 95 percent of physicians would continue to participate. Let us make it the hardest possible question. Do you believe that—with respect to physicians providing inpatient services, that there would be any substantial diminution of participation?

Dr. TODD. Yes, sir, I do, for a variety of reasons. First is HCFA's information in the "Health Care Review." We can enter the article in the record if you would like.

Chairman HEINZ. I am flattered that a Government agency should be considered the authoritative source of how physicians are going to behave. This is the first time to my knowledge that anybody has said, "You people in the Federal Government have finally gotten it right, you know how to predict other people's behavior."

Dr. TODD. We are not sure we have gotten it right as I am also going to give you figures based on our polling, which are a little different from that. And, indeed, among the internists the pollings suggested it may indeed be higher than what HCFA suggests.

So I am not saying HCFA is correct, I am saying it is within the a range of possibilities.

Chairman HEINZ. HCFA forecast that the cost of the entire medicare program, which is now $60 billion, would be less than $15 billion this year. Now, if they are off by a similar percentage——

Dr. TODD. Which they may be on the upward side.

Chairman HEINZ. Or on the downward side.

Dr. TODD. But I think, as I said earlier, mandatory assignment forces the physician to make a very difficult decision. It forces his patient to make a very difficult decision. And I think faced with an all or nothing aspect, the physician is hopefully going to be much more interested in his ability to resist further incursions into his freedoms and his patient's freedoms, in order to provide the sort of care that he believes his patient needs, and also may not want to deny his patients access to continuing care with the patient's individual physician.

I think the HCFA figures are reasonable, too low.

Chairman HEINZ. Let me ask Dr. Rice about that. He is supposed to be an expert in that area. Dr. Rice, what do you think about this HCFA report?

Dr. RICE. The figures that Dr. Todd is referring to were from an article by Janet Mitchell and Jerry Cromwell, which appeared recently in the "Health Care Financing Review." In their study, physicians were asked if they would accept all or none of their medicare patients on assignment, if they were given the choice. Two-thirds responded that they would accept no patients on assignment. However, three important points must be made about these figures: (1) These are physician responses to a hypothetical situation. In fact, physicians had an incentive to say that they would accept no patients on assignment, because this would convince Congress that changing the assignment regulations would be a bad idea. (2) The survey was done in 1976. There are considerably more physicians now, and many might not be able to compete effectively if they refused to assign their medicare patients. (3) In the survey, physicians were not asked to choose between mandatory assignment of medicare patients, and refusing to see medicare patients. It is unlikely that physicians would drop out of the medicare market if assignment were mandatory, since medicare patients comprise a major share of many physicians' practices.

As I mentioned earlier, I would favor a compromise between the present system of claim-by-claim assignment and mandatory assignment for all patients. This compromise would be mandatory assignment for inpatient services. Mandatory assignment for inpatient services would have certain advantages: It would provide physicians with an incentive to deliver outpatient rather than inpatient services, and it would shield beneficiaries from the large liabilities associated with nonassigned inpatient services.

I do not think that it would jeopardize access to care very much, either. About 40 percent of U.S. patient days in hospitals are accounted for by the elderly; adding on the disabled would make this figure even higher. Because physicians find hospital services to be very profitable, I do not believe that many would drop out of the medicare program if assignment were mandatory for such services.

Chairman HEINZ. Will that be a savings for medicare?

Dr. RICE. It will be a savings for beneficiaries because there will be no added costs for inpatient surgery. It will only be a savings for medicare if physicians treat more in their patients in outpatient settings.

Chairman HEINZ. To a certain extent, that might happen?

Dr. RICE. To some extent, yes.

Chairman HEINZ. What do we know about the unassigned claims, distribution of unassigned claims between outpatient visits and inhospital?

Dr. RICE. What I am familiar with right now is that the services provided by hospital based physicians, such as pathologists and radiologists, are more likely to be assigned. Otherwise, I don't think there are tremendous differences in inpatient and outpatient assignment rates.

Chairman HEINZ. I have got one last question for Dr. Todd.

Dr. Todd, Dr. Reinhardt suggested that maybe the United States should somehow—with great difficulty, obviously—move in the direction of the way Canada has moved with respect to negotiating fees. Now, I understand all the difficulties in getting from here to there. The AMA claims only 45 percent of the membership among physicians in this country. It is not a union, per se, it does not seek to be a collective bargaining union; I understand all of that.

But there are some problems with fee structures. Our committee did an investigation that I think pretty conclusively demonstrated that pacemaker fees are just ridiculous, still being reimbursed as if it was open chest surgery. Now, what do we do? How do we solve that problem? Or do we just ignore it?

Dr. TODD. No; I would have three answers to that.

First of all, in terms of the high charges for initial technology, I think you are beginning to see, and indeed in the medical literature, those physicians who already are beginning to make a call and a request as these procedures become routine, to reduce the cost of them. I think that is going to continue.

And, second, organized medicine at all levels has had some interest in relative value scales, profiles, and so forth, but have been frustrated at every turn by the Federal Trade Commission and Justice Department who say it is inappropriate for us to get into fee disputes, fee setting, and so forth. So that if we were joined by the Government in some sort of fee negotiations we would have to have some relief from the FTC in their current position.

And, last, when I say that American Medical Association only represents less than 50 percent or only shows on its membership rolls, which is a more appropriate way of expressing it, some 40-odd percent of physicians in this country, bear in mind that in our House of Delegates, which is the policymaking body, we have 61 specialty societies represented. And the attitudes and positions and activities of the American Medical Association are carried back to these various areas.

We have evidence to show that less than 10 percent of physicians in this country do not belong to some sort of an organized medical program. So I think that the negotiating possibility is there.

Chairman HEINZ. Let me ask you this: Dr. Reinhardt specifically suggested that fees should be related to costs and the principal measure of cost was time. Now, without figuring out how we are going to implement such a notion, would you generally endorse it?

Dr. TODD. I think perhaps Professor Reinhardt has oversimplified the time issue.

Chairman HEINZ. He did not say it was the only component. He just said it was a substantial relationship.

Dr. TODD. Even within that category, you have to take into account the training of the individual, the experience of the individual, the severity of the service that he is rendering——

Chairman HEINZ. I do not think he is guilty of oversimplification. I am—but I am just trying to be brief.

Dr. TODD. I think it would be very difficult to again reach an agreeable hourly rate for procedures that would adequately compensate all of those.

Chairman HEINZ. So you do not endorse the concept of relating fees to cost in the broadest sense of the word?

Dr. TODD. In the broadest sense, yes. In relating the fee to the amount of training, time, energy, the quality of services, yes, I think that is a perfectly reasonable way to do it.

Chairman HEINZ. Would you say our fee schedule is not related to that?

Dr. TODD. Some do and some do not.

Chairman HEINZ. That is a big problem.

Well, Senator Burdick, do you have additional questions?

Senator BURDICK. Just one additional question.

Mr. Hutton, would you elaborate on what you said about medigap insurance?

Is it too costly for the average person, or is there inadequate coverage? What is the problem?

Mr. Hutton. Well, we find from our own insurance, for example, that we hold insurance companies at arms' length. We have an insurance administrative group, and they send out to the various insurance companies the particulars of the kind of insurance that we want, and they bid on that. And we accepted the lowest bidder in terms of the cost to our people.

There are no administrative costs paid the National Council by the insurors—so the program is cheaper for the members.

However, even in that kind of insurance, the costs have gone up considerably over the last 5 years. And, in fact, as the changes in medicare take place, as the Government asks for more coinsurance factors and more this and more that, most of these medigap policies have been made unprofitable.

I know several that lost a great deal of money in the last few years, the one that covered us did. And the costs have gone up considerably. Older people cannot keep pace with these things.

Ms. Ostrander. Senator Burdick, we have some information in our full statement, because I was bothered by the data that was given. There is evidence that fewer and fewer of the elderly are financially able to retain medigap. And in Florida Blue Cross-Blue Shield has recently pointed out that persistently rated, for example, the percentage of those aged beneficiaries who had been covered at the beginning of the year and continued to have coverage at the end of the year, have dropped from 93.3 percent in 1978 to 86.9 percent in 1982. That is not included in that figure in percentages. That strictly relates to the cost of part B.

Dr. Rice. Can I add something?

Senator Burdick. Yes.

Dr. Rice. It is my understanding that medigap policies provide good coverage for medicare's deductibles and coinsurance, but little coverage for the services that medicare does not cover. For example, very few policies cover: (1) The liability associated with nonassigned claims; (2) most nursing home costs; or (3) prescription drugs. Thus, the most costly services—those that are not well covered by the medicare programs—are also not covered by medigap policies. However, it is important to note that many insurance companies are responding to State regulations, which require coverage for the deductibles and copayments associated with medicare, but have no requirements that medigap policies cover the services which medicare does not cover, either.

Senator Burdick. Thank you.

Chairman Heinz. Thank you very much, Ms. Ostrander and gentlemen. You have been extremely generous with your time. You have given us some very good food for thought, some good ideas. And I appreciate your time and attention to this hearing.

Thank you.

The next panel is composed of Dr. Thomas Delbanco, M.D., Susan Babin, Dr. Janet Mitchell, Ph. D., accompanied by Dr. Jerry Cromwell, Ph. D.

Ladies and gentlemen, would you please come forward.

Dr. Delbanco, would you please proceed.

STATEMENT OF DR. THOMAS L. DELBANCO, ASSOCIATE PROFESSOR OF MEDICINE, HARVARD UNIVERSITY, AND DIRECTOR, DIVISION OF GENERAL MEDICINE AND PRIMARY CARE, BETH ISRAEL HOSPITAL, BOSTON, MASS.

Dr. Delbanco. Thanks for inviting us today.

I am a practicing general internist and teach medicine at the Harvard Medical School.

I will try and talk briefly from the practicing doctor's point of view. Let me first point out that while my clinical experience has taught me that fewer days in the hospital and fewer laboratory tests may often signify the best medical care for my patient, it is simply not in my financial best interest today to withhold care or suggest that less care can be just as good. If I am an ophthalmologist, depending on where I practice, medicare will pay me $500 to $1,400 to extract a cataract, but may give me only $20 or $30 to suggest that it is not time for the clouded lens to come out. The surgeon, aware of the current medical debate about silent, asymptomatic, gallstones has to make recommendations with the knowledge that $700 is paid for hours in the operating room and several follow visits in the hospital when the stones come out, but only $30 may be paid for the hour spent convincing the patient that the gallstones can stay in.

Two weeks ago my daughter had a wart removed from the bottom of her foot by a surgeon who spent 15 minutes with her. It was done in his office; he charged Blue Shield $75. On the other hand, if I take half an hour in my office trying to interrupt the disastrous course of alcoholism or depression, I may be paid $20. It is ludicrous that a cardiogram, which costs virtually nothing to perform and takes about 30 seconds to evaluate, garners $30 to $40, while an hour's careful evaluation of fatigue and weight loss is worth no more. In fact, at the end of that session, the patient may ask me to please perform a laboratory test because otherwise medicare would not pay for the cost of any of that time.

In more technical jargon, we refer to an imbalance between what physicians are paid for cognitive function, or more simply, the doctor's time, as opposed to the premium paid for procedures and tests. The fee payment methodology known as UCR in Blue Shield, or CPR in medicare, has not produced this imbalance, but has accentuated it. By now it has really engraved it in stone.

Before I make some suggestions for change, let me emphasize a phenomenon that today makes a prediction about the impact of any change very difficult. Most agree that we really are producing too many doctors today. Five years ago my phone would ring three times a week with the director of another practice requesting help in finding a doctor to join that practice. Today when the phone rings, it is almost invariably a doctor looking for a job.

Everyone has his own guess about the consequences. Some argue that doctors will start increasingly to compete for patients in a healthy way, hoping to attract them by charging lower fees and offering better service. Access could improve, accompanied perhaps with the offer of a free health examination to induce the patient to join the practice. Patients who are poor and near poor may be welcomed because of an open slot in the appointment book. In the past, they might have been shunted aside to make room for a fully paying customer.

On the other side of the coin, the doctor may frantically try to make the best of what he views as a very threatening financial situation. He may spend a lot of time convincing you that it is really in your best interest to see him every month, rather than once a year. In addition, if he still is rewarded for every test he orders, the doctor, who is quite inventive, may use a lot of unproven or marginal technologies in order to earn what he deems appropriate.

I do not think anyone can predict what will happen, and we cannot even be sure that a true excess of physicians will exist. Hopefully, we will be prepared and better able to serve unmet needs. But perhaps costs will skyrocket inappropriately at society's expense.

Let me come back to suggest how medicare might begin to change the process by which fees are set. I would like to urge you to consider discarding the CPR fee payment method and consider adopting a negotiated fee schedule.

If medicare turned to a fee schedule payment plan there would be an unusual opportunity to change relative values currently assigned to different services, tests, and procedures. Some of the incentives that can result in marginal health care could be modulated or hopefuly abolished.

The tough question is how to negotiate a fee schedule in which all interested parties will be able to compromise and reach a consensus about what is worth what, relative to everything else. It is very easy for me, a primary care doctor, to urge that fees should be increased to reflect the true value, as I define it, of 1 hour of my work. It becomes an awful lot more complicated if the total dollars available are finite and some other doctor has to be paid less in return. It becomes clear that there will be many interested parties who will be hard put to place self-interest aside and agree to make less money, so that a colleague in another specialty can make more.

There is an experiment occurring right now in Washington, the success of which may hold real relevance for developing a mechanism to negotiate physicians' fees. The Congress has mandated a commission to address prospective hospital payments. It is composed of individuals representing broad constituencies and interested parties. It is much too early to know if the commission will have any impact, but perhaps we should apply similar reasoning to a process for negotiating physicians' fees.

Let me suggest that you convene a group of interested parties, including physicians from different specialties, patients, and individuals, representing those who have to pay the bill. The mandate will be for this group to restructure the relative values to which I have referred and to address also the issue of assignment under medicare part B.

Could such an organization over time develop fee schedules which accurately reward different skills and procedures and, most importantly, reward high quality medical practice?

I am personally encouraged by discussions with many physicians in practice and academic settings, from different specialties and subspecialties. They appear willing to try to tackle this issue.

Not one of us should depend on a cardiogram for income. We want to be rewarded for taking the time to help a patient. There should not be one of us tempted to hospitalize a patient when we feel it would be in his best interest to keep him out of hospital. While exceptions can always be found, and glaring headlines can be built from those exceptions, most physicians I know work very hard and care deeply about their patients. They would like to function in a rational system that rewards them for their best efforts fairly, without tempting them to convince their patients to undergo treatment of marginal value.

A national forum for negotiation that would maintain the fee for service model, while changing incentives and some of the imbalances that now exist might provide a very exciting start. I believe this is something you should look at. This is the kind of process that is being tried now in Massachusetts, and it is this experiment that Ms. Babin is now going to describe to you.

Thank you.

Chairman HEINZ. Thank you.

[The prepared statement of Dr. Delbanco follows:]

PREPARED STATEMENT OF DR. THOMAS L. DELBANCO

My name is Thomas Delbanco. I am a board-certified, practicing general internist; associate professor of medicine at Harvard Medical School; and chief of the division of general medicine and primary care at Beth Israel Hospital, one of the Harvard teaching hospitals. I am also director of the Henry J. Kaiser fellowship program in general medicine at Harvard Medical School, a program that prepares general internists for careers as teachers and scholars in primary care and general medicine. Six years ago I was privileged to work in the Congress as a Robert Wood Johnson health policy fellow with Senator Bob Dole and Congressman John Moss. During that time, I conducted an inquiry into Blue Shield's system for paying the physician's fee and developed my interest in the area you are addressing today.

This committee has held fascinating hearings in recent months addressing some of the consequences of increased longevity. All too often today we have to focus on the cost of health care, and you have had to examine strategies for holding down the cost of hospital care and maintaining medicare's fiscal solvency. It is entirely fitting that you now turn your attention to the physician who has both had an exciting time managing patients with new insights and technologies and has also, at times, profited financially from these developments. Over the past 5 years, the incomes of individual physicians have risen at a rate faster than the CPI, and the percentage of money medicare spends on physicians has grown. Let me turn to a necessarily general description of the financial incentives faced by the majority of physicians practicing today. Let me then suggest a direction which the Congress might take to bring about constructive change.

While my clinical experience has taught me that fewer days in the hospital and fewer laboratory tests may signify the best medical care for a patient, it is certainly not in my financial best interest to withhold care or suggest that less can be just as good. If I am an ophthalmologist, depending on where I practice, medicare will pay me $500 or $1,000 to extract a cataract, but will give me only $20 to suggest that it is not time for the clouded lens to come out. The surgeon, aware of the current medical debate about silent (asymptomatic) gallstones may be influenced by the knowledge that $700 is paid for 1½ hours in the operating room and several follow-up visits in the hospital when the stones come out, but only $30 is paid for the hour spent convincing the patient that the gallstones can stay in. Two weeks ago my daughter had a wart removed from the bottom of her foot by a surgeon who took 15 minutes. It was done in his office and cost Blue Shield $75. On the other hand, if I take half an hour in my office trying to interrupt the disastrous course of alcoholism or depression, I may be paid $20. It is ludicrous that a cardiogram which costs virtually nothing to perform and takes about 30 seconds to evaluate garners $30 to $40, while an hour's careful evaluation of fatigue and weight loss is worth no more.

In our more technical jargon we refer to an imbalance between what physicians are paid for cognitive function (or, more simply, a doctor's time in the office) and the premium paid for procedures and tests. The fee payment methodology known as "usual, customary, and reasonable" (UCR) in Blue Shield, equivalent to "customary, prevailing, and reasonable" (CPR) in medicare, has not produced this imbalance but has accentuated it and by now engraved it in stone. How does it work?

Today medicare generally pays physicians on a fee-for-service basis. It pays on the basis of the physician's charge, limited by ceilings for a given service that are determined both by the area in which the physician practices and by the physician's own pattern of charges. Medicare offers physicians the option of "acceptance of assignment." Physicians who accept assignment are paid directly by medicare; they agree to bill the patient for no more than the 20 percent coinsurance. Physicians who do not accept assignment bill the patient directly for whatever fees they decide on. The patient then bills medicare and receives the allowed fee, minus coinsurance. The physician can accept or reject assignment on a case-by-case basis.

Concern about rising costs led to the establishment of an economic index that was enacted by Congress as part of the 1972 Social Security Amendments. The economic index limits annual increases in medicare's "prevailing" allowances nationwide to a fixed percentage. Set by the Secretary of Health and Human Services, the index reflects changes in the cost of living, physicians' operating costs, etc.

The economic index is applied nationally, but other factors contribute to considerable variations in the medicare program from region to region. Individual medicare carriers hold considerable discretionary authority. For example, they decide whether specialists and nonspecialists are to receive the same fee for the same procedure, and they determine whether board certification should affect the level of payment. In some instances, charge data for medicare and Blue Shield patients are merged; in others, they are not. These and other factors magnify the enormous regional variation in allowable charges for given procedures.

Before I make some suggestions for change, let me emphasize a phenomenon that today makes any prediction about the impact of change extremely difficult. Most agree that we are training too many doctors today. Five years ago my phone would ring three times a week with a director of another practice requesting help in finding a physician to join the practice. Today when the phone rings, it is a physician looking for a job. Everyone has his own guess about the consequences. Some argue that doctors will start increasingly to compete for patients in a healthy way, hoping to attract them by lower prices and better service. Access may improve, accompanied perhaps with the offer of a free health examination to induce you to join my practice. Patients who are poor and near-poor may be welcomed because of an open slot in the appointment book. In the past, they might have been shunted aside for a fully paying customer.

On the other side of the coin, the doctor may frantically try to make the best of what he views as a very threatening financial situation. He may spend a lot of time convincing you that it is really in your best interest to see him every month, rather than once a year. In addition, if he still is rewarded for every test he orders, the doctor—who is quite inventive—may use a lot of unproven or marginal technologies in order to earn what he deems appropriate.

I do not think any one can predict what will happen, and we can not even be sure that a true excess of physicians will exist. Hopefully, we shall be better able to serve unmet needs. But perhaps costs will skyrocket inappropriately at society's expense.

There are more and more programs that are now casting aside fee-for-service and paying the physician a salary. HMO's and other comparable programs, in effect, pay for the physician's time, except in those few cases when they have to contract for services from specialists who they cannot justify (or afford) retaining on a full-time basis. If one argues, however, that fee-for-service will continue to represent the majority of practice patterns, two other options can be considered by medicare. They include: changing the types of service that medicare pays for and/or changing the way medicare sets allowable fees.

Let me now suggest how medicare might change the process by which fees are set. I urge you to consider discarding CPR and turning to a negotiated fee schedule. What does this mean?

A fee-schedule, known in the insurance industry as an indemnity policy, pays within clearly defined limits. In a given State or region, fixed rates are established for procedures, tests, and services that the policy covers. A subscriber holding a fee-schedule policy knows that a fixed price will be paid for a given service; the physician can likewise count on receiving a set payment that may or may not cover the fee charged. The amount and scope of coverage vary widely among different policies.

The history is quite instructive. Such plans first emerged to cover acute, hospital-based medicine. As specialization increased, and with it the need for fee schedules to state precisely what was to be paid for, Blue Shield and other insurance plans paid physicians for specified diagnoses, tests, and procedures. From their earliest days, such policies seldom covered routine examinations or other office visits. As a result, patients were partially protected from the costs of illness associated with hospitalization, including the costs of physicians' services, but very few services that did not involve hospitalization were covered. It is only in more recent years that preventive service and office-based practices have begun to be covered by such insurance plans.

If medicare turned to a fee schedule payment program, there would be the opportunity to change the relative values assigned to different services, tests, and procedures. Some of the incentives that result in marginal health care could be abolished or at least modulated. The tough question is how to negotiate a fee schedule in which all interested parties will be able to compromise and reach consensus about what is worth what, relative to everything else. It is very easy for primary care practitioners to urge that their fees should be increased to reflect the true value (as they define it) of 1 hour of work, but it becomes much less simple if the total dollars available are finite, and some other physician has to be paid less in return. It becomes clear that there will be many interested parties who will be hard put to place self interest aside and agree to make less money so that their colleague in another specialty could make more.

One experiment is occurring right now in Washington, the success of which may hold real relevance for developing a mechanism to negotiate physican fee schedules. The commission addressing prospective hospital payments that was established recently is composed of individuals representing a broad constituency of interested parties. It is far too early to know if the commission will have any impact, but perhaps we should apply similar reasoning to a process for negotiating physicians' fees. Let me suggest that the Congress convene a group of interested parties, including physicians from different specialties, patients, and individuals who have to pay the bill. The mandate would be for this group to restructure the relative values to which I have referred and to address also the issue of assignment. Could such an organization over time develop fee schedules which equitably reward different skills and procedures and, most importantly, reward high quality medical practice? This is the process that is being suggested for Massachusetts, and it is this experiment that Ms. Babin will describe. I believe it bears careful watching over the next years both in terms of its impact on the political process and on patterns of care.

My sense is that physicians, perhaps with a necessary prod from external forces, may indeed have some success if they sit down at the same table with a clear mandate to resolve some of their differences. We, as physicians, are worried enough about losing some of the very special aspects of the patient-physician relation. With so many storm clouds on the horizon threatening that relation, I hope we will be wise enough to take this as a warning to get our own house in order. I am encouraged by discussions with physicians in practice, in academic settings, from different specialties and subspecialties. They appear willing to try and tackle this very knotty issue. Not one of us should depend on a cardiogram for income; we want to be rewarded for taking the time to help a patient. There should be not one of us who hospitalizes a patient when we think it would be in his best interest to keep him out of the hospital. While exceptions can always be found and glaring headlines can be built from those exceptions, most of the physicians I know work very hard, care deeply about their work and their patients, and would like to function in a rational system that rewards their best efforts fairly without inducing them to convince their patients to undergo treatment of marginal value. A national forum for negotiation that would maintain the fee-for-service model, while changing incentives and some of the imbalances that now exist, might serve as a very exciting start. I believe this is something you should consider seriously.

Thank you very much.

Chairman HEINZ. Ms. Babin.

STATEMENT OF SUSAN BABIN, BOSTON, MASS., DIRECTOR, BUREAU OF COMMUNITY BASED SERVICES, RATE SETTING COMMISSION, COMMONWEALTH OF MASSACHUSETTS

Ms. BABIN. Thank you, Mr. Chairman.

I am director of the Massachusetts Rate Setting Commission's Bureau of Community Based Services. The rate setting commission is mandated to set fair, reasonable, and adequate rates for health, educational, and social services purchased by governmental units, including the State medicaid program.

The bureau which I direct oversees the setting of rates paid by governmental agencies for all noninstitutional health, education, and social services.

In my capacity as director I am responsible for developing methods for the Commonwealth to pay for physician services. I am pleased to appear before you today to describe the Commonwealth of Massachusetts' present approach to the complex issues of dealing with reimbursement for physician services.

In December 1983, the commission implemented a physicians' fee schedule which is a radical departure from the traditional ways in which rates for physicians' services have been set. Many of these ways have been described today. The new system attempted, for the first time, to relate prices to the costs of delivering care and consequently to correct price discrepancies which have developed over the years between primary care and surgical and technological procedures, the very kind of discrepancies that Dr. Delbanco has just described.

The net effect of the new fee schedule was dramatically to increase fees for office visits and to reduce or freeze at their then current levels fees for surgical, radiological, and anesthesia procedures.

The reimbursement model we used was based on a study conducted by a health economist and a physician, William Hsaio, Ph.D. and William Stason, M.D., of the Harvard School of Public Health, in which they assigned relative values to 25 surgical procedures and to two office visits based on resource costs, which included the cost of training, costs of overhead, the time it took to perform the procedure, and the complexity of procedure.

Their studies showed that, relative to office visits, traditional reimbursement levels overvalued the surgical procedures.

According to their model, an appendectomy should have been 4.7 times an office visit. If you look at the Massachusetts Blue Shield profiles or the Massachusetts Rate Setting Commission fee schedule in 1981, an appendectomy, instead of being 4.7 times an office visit, was 13 times an office visit.

We used the values of Dr. Hsaio and Dr. Stason and applied them directly to similar procedures in our fee schedules, and then we adopted their model to the other procedures that were not studied by them.

The impact of our system on physicians is dramatic. Pediatricians, who are traditionally the relatively lowest paid physicians, will receive the largest overall increases of about 40 percent, while general surgeons will receive the smallest, about 6 percent. General practitioners and family practitioners also stand to gain with projected increases of about 35 percent. Ob-gyn physicians who generate some of their revenue from primary care and some from surgery will increase revenues by about 20 percent.

The point is, that the more likely the physician is to treat in the office rather than in the operating room, the greater his increase in reimbursement under our system. Thus, there is a very direct incentive to provide nonprocedure oriented services.

A particular note is that some of the fees for surgical procedures which were reduced the most, such as an appendectomy or hysterectomy, are those well documented as being overutilized.

We do not pretend that our new system is perfect. We have extrapolated a study of 25 procedures to 2,400, a risky undertaking at best, in purely scientific terms. That is why fees for the 2,400 procedures that were not studied in the Hsaio-Stason report, were just frozen at current levels instead of reduced. But we feel that the system at least moves the pricing system in the right direction in the context of calls from health economists and policy experts, and even some physicians' groups, to change the way in which reimbursement has been done over the years.

We have asked the Massachusetts Society to choose 20 to 25 additional procedures for us to evaluate for next year's rate review, and we plan to convene a panel of physicians to help us expand the Hsaio-Stason model by adding more procedures each year, thereby refining the system on an ongoing basis.

With limited resources available to us, this will obviously be a slow undertaking if left to Massachusetts alone. Therefore, we would welcome any Federal projects that would expand study.

With health care costs rising and dollars becoming limited, there is a pressing need not only to contain costs, but to look at the ways we can restructure our priorities. We feel that the Massachusetts approach to reimbursement is a rational one that attempts to move the system in a rational direction. We would hope that this model will be expanded and refined by others.

Thank you.

Chairman HEINZ. Thank you.

[The prepared statement of Ms. Babin follows:]

PREPARED STATEMENT OF SUSAN BABIN

Mr. Chairman and members of the committee, my name is Susan Babin and I am director of the Massachusetts Rate Setting Commission's Bureau of Community Based Services. The Rate Setting Commission is mandated to set "fair, reasonable and adequate rates" for health, educational, and social services purchases by governmental units, including the State medicaid program. The bureau which I direct oversees the setting of rates paid by governmental agencies for all noninstitutional health, educational, and social services.

In my capacity as director, I am responsible for developing methods for the Commonwealth to pay for physicians' services. I am pleased to appear before you today to describe the Commonwealth of Massachusetts' present approach to the complex issue of reimbursement for physicians' services.

In December of 1983, the Commission implemented a physicians' fee schedule which is a radical departure from the traditional way in which rates for physicians' services have been set. The new system attempted, for the first time, to relate prices to the costs of delivering care and consequently to correct price discrepancies which have developed over the years between primary care and surgical and technological procedures. The net effect of the new fee schedule was dramatically to increase fees for office visits and to reduce, or freeze at their then current levels, fees for surgical, radiological, and anesthesia procedures.

The reimbursement model we used was based on a study conducted by William Hsaio, Ph. D., and William Stason, M.D., of the Harvard School of Public Health in which they assigned relative values to 25 surgical procedures and two office visits based on resource costs (cost of training, overhead, complexity of procedure and time). Their study showed that, relative to office visits, traditional reimbursement levels overvalued most surgical procedures. The changes in the Rate Setting Commission fee schedule were developed using the relative value scales from the Hsaio-Stason model.

Initially, we developed a methodology which expanded this model to all 24,000 medical and surgical visits and procedures covered by medicaid. This methodology generalized the Hsaio-Stason procedures to other procedures not studied by them on a subspecialty basis by assigning a relative value for each subspecialty and one for primary care. This approach would have resulted in increases in primary care fees, increases in some subspecialty fees and decreases in others.

At the suggestion of the Medical Society, we made two changes. First, we modified the initial methodology by creating one relative value for primary care and one for all other specialties. This change had the effect of reducing fees for all nonprimary care specialities by the same amount (even though some would have increased in our first proposal) while still increasing fees for primary care. Second, although we did reduce fees for 17 of the surgical procedures studied by Hsaio-Stason, we held constant all other fees that would have been reduced under the new metholodolgy until we are able to evaluate them more thoroughly.

The new schedule contains increases in office visits and other primary care services ranging from 12 to 83 percent. The most commonly occurring visit, the routine office visit, increased by 83 percent (from $11.50 to $21). On the other hand, 17 surgical procedures were reduced by amounts ranging from 4 percent for varicose vein surgery to 59 percent for a dilatation and curettage (D & C).

Underlying the changes we implemented in our schedule is the assumption, reiterated over the past few years by health economists, policy experts and even some physician groups, that traditional physician reimbursement systems such as medicare and Blue Shield have led to an inappropriate gap in fees between primary care and technologically-oriented procedures. Traditional reimbursement systems are usually based on physician established charges, and do not necessarily reflect the costs of providing services, as one can see from the Hsaio-Stason study. Their study shows, for example, that an appendectomy, in terms of resource costs, has a value 4.7 times that of an office visit, but in 1982 the rate paid by the Massachusetts Blue Shield and medicaid programs for an appendectomy was 13 times the rate for an office visit. Such systems produce what is, in effect, disproportionately high revenue for more costly procedures.

The ramifications of such pricing systems on health care costs are far-reaching. In the short run, they encourage the substitution of more costly and resource-intensive forms of diagnosis and treatment for less costly diagnosis and treatment. In addition, a financially-based preference for surgery increases the costs of hospitalization. In the long run, the more favorable remuneration for technological procedures as opposed to primary care and office visits provides incentives for new physicians to specialize, thus resulting in a shortage of primary care providers.

These policy implications of the traditional pricing methodologies led us to devise a system which would reverse the described trends. The impact of our system on physicians is dramatic. Pediatricians, traditionally the relatively lowest paid specialists, will receive the largest overall increases (about 40 percent) while general surgeons will receive the smallest (about 6 percent). General practitioners and family practitioners also stand to gain, with projected increases of approximately 35 percent. OG-GYN physicians, who generate some of their revenue from primary care and some from surgery, will increase revenues by about 20 percent. The more likely the physician is to treat in the office, rather than the operating room, the greater his increase in reimbursement. Thus, there is a very direct incentive to provide nonprocedure oriented services. Of particular note is the fact that some of the surgical procedures which were reduced the most (D & C, appendectomy, Caesarian section) are those which are well documented as being overutilized.

We do not pretend that our new system is perfect. We have extrapolated a study of 25 procedures to 2,400, a risky undertaking at best in purely scientific terms. But at least our present model moves the pricing system in the right direction in the context of public policy. We have asked the Massachusetts Medical Society to choose 20 to 25 additional procedures for us to evaluate for next year's rate review, and we plan to convene a panel of physicians to help us expand the Hsaio-Stason model by adding more procedures each year, thereby refining the system on an ongoing basis.

With limited resources available to us, this will obviously be a slow undertaking. Therefore, we would strongly support any action taken by the Federal Government to develop projects that would expand the Hsaio-Stason model. With health care costs rising and dollars becoming limited, there is a pressing need to restructure our priorities. The Massachusetts Rate Setting Commission's physician reimbursement system is a beginning approach to a rational reimbursement policy which accomplishes this restructuring. We hope that in the future this model will be refined and expanded.

Chairman HEINZ. Dr. Mitchell.

STATEMENT OF JANET B. MITCHELL, PH. D., VICE PRESIDENT, HEALTH ECONOMICS RESEARCH, INC., CHESTNUT HILL, MASS., ACCOMPANIED BY JERRY CROMWELL, PH. D., PRESIDENT

Dr. MITCHELL. Thank you, Mr. Chairman, for inviting me here today. I am vice president of Health Economics Research, a Boston-based public policy research firm, and I have spent the last 8 years studying physician responses to the medicare and medicaid programs.

Dr. MITCHELL. With me is my colleague, Dr. Cromwell.

We believe that fee freezes are going to be disappointing in the long run, and that effective cost control can only be achieved by controlling prices and the number of services simultaneously, and that this requires an innovative approach to reimbursing physicians. Let me explain why we think this is the case.

First of all, expenditures for physicians' services are increasing in large part because physicians are doing more of everything, more lab tests, more surgery, more X-rays. This occurs partly because the elderly population is growing. But it also happens in a couple of subtle ways, what we call the unpackaging of physician services and the involvement of multiple physicians.

Unpackaging is the practice of submitting an itemized bill for every service provided. Just like ordering a la carte from a restaurant menu, the total bill is invariably higher. Similarly, a single episode of illness includes more and more physicians, each one of whom submits an independent bill to medicare or to the patient.

Take a routine surgical admission, for example. Besides 11the surgeon and the anesthesiologist, there may be an assistant surgeon, a radiologist, a pathologist, a variety of consulting specialists, plus the patient's personal family physician, who is providing routine hospital visits. And these routine visits, of course, are all in addition to the followup care that has to be provided by the surgeon who performed the operation.

We recently completed a 2-year HCFA-funded study that explored new ways of packaging physician services, approaches that redefine the payment unit from a specific procedure to a more comprehensive bundle of services. The major advantage to these packages is that they encourage the physician to take a broader view of the patient care process with incentives to cut back on marginal procedures.

Under the current system, the physician bears no financial risk in ordering tests or requesting consultations. He uses the services of other physicians in his treatment of the patient without having to pay for them. But the financial burden of this care is borne wholly by the beneficiary and by the medicare program. By packaging physician services, we can restore much of the responsibility back to the physician who made the treatment decisions in the first place. Packages are also less intrusive, in that responsibility for monitoring utilization rests with the physician rather than with outside agencies.

HMO's, of course, can be considered the ultimate kind of package in which all services, physician and hospital, are bundled together in a single capitated payment. We developed packaging approaches that are less comprehensive than HMO's, but which could be more easily incorporated into the fee for service reimbursement system, and we then simulated what these packages might look like using actual medicare claims in two States, Michigan and South Carolina.

One approach is an inpatient condition package, which has become popularly known as physician DRG's, which would encompass all physician services provided during the hospital stay. DRG-like methods could be used to combine the charges of multiple physicians and then average these charges over the hospitalization to arrive at a single lump-sum payment.

Besides removing all incentives to unbundle services, this approach could also encourage physicians to be more efficient in their choice of other physician services. This is an incentive which is totally absent from our present system. The use of national DRG weights, such as those currently used in medicare hospital reimbursement, would also eliminate geographic disparities.

Consider lens extraction, for example, which currently is the fourth most common medicare DRG. We found that total physician payments for this DRG averaged 44 percent more in Michigan than in South Carolina. Well, we know it costs a lot more to live in Michigan. But the cost-of-living difference accounted for only one-fourth of this big price difference.

We found that lens extraction costs more in Michigan largely because of greater physician intensity. Michigan ophthalmalogists are 10 times more likely to use an assistant surgeon during the operation and are twice as likely to involve medical specialists in the care of the patient.

On the other hand, physician DRG's have the same potential disadvantages that the hospital DRG's do. Physicians may have incentives to upgrade the diagnosis or to readmit patients in order to maximize reimbursement. They may also skimp on necessary tests and consultations. But presumably, the same institutional safeguards built into the hospital prospective payment system could also be directed at physician services.

Physician DRG's would also fundamentally alter interspecialty relationships. Hospital-based physicians, like radiologists, pathologists, and anesthesiologists, would probably resist DRG packages as they no longer could bill medicare or medicare patients directly. Their incomes would be directly dependent on the attending physicians.

In turn, attending physicians may resist this approach because of the financial risk involved and because of the added hassle of negotiating with the other physicians. This could lead to lower assignment rates, especially for high cost DRG's. Negative responses may be much more likely if DRG,s do not adequately capture illness severity from the physician's perspective, and this could happen since the current DRG's were originally developed to capture case mix differences across hospitals, not across physicians.

Inequities could also rise for some physicians because, as we have just heard, surgery and hence surgical DRG's are valued far higher than medical DRG's. Lens extraction packages, for example, would be priced 2 to 4 times higher than packages for care of a stroke patient.

There is, however, a strong alternative to physician DRG's, and that would be to base the package on a specific surgical or diagnostic procedure rather than the complete medical problem or DRG. Although much narrower in scope, this type of package may be more acceptable to physicians and be easier to implement.

Another difference is that this type of package, which we have called a special procedure package, would apply wherever the procedure was performed. This would reduce the current disparity in reimbursement for procedures performed in outpatient versus inpatient settings.

Now, how physicians will respond to these new approaches is going to depend critically on how they are implemented. Under our current system, each physician bills and gets paid separately for his or her own services. But now when we are packaging the services of multiple physicians together, who would be paid?

There are basically two choices, or two main choices, the physician and the hospital. In paying the physician, we would first have to identify the principal physician, like the surgeon or the attending physician, and this physician would be paid a lump sum for all package services. He, in turn, will be responsible for any payments to other physicians.

This approach has the major advantage of delegating fiscal responsibility to a single physician, but would also fundamentally alter relationships among physicians, and could encounter resistance as a result.

An alternative is to give the hospital a lumpsum payment for both part A and part B services, and the hospital would then arrange payment to the individual physicians. This approach also has considerable intuitive appeal, but it implies a fundamental redefinition of physician services under medicare.

The second important implementation issue that has been discussed already today concerns how to handle medicare assignment under these types of packages. If the combined physician/hospital DRG payment is made to the hospital, in-patient physician services are effectively redefined as a hospital service, and the whole concept of assignment no longer applies.

What happens if the DRG payment is made to the physician though instead of the hospital?

Well, first of all, the cost control incentives are considerably diluted unless the physician accepts assignment. If he does not accept assignment, it is business as usual, as far as the physician is concerned. The patient, on the other hand, would have to pay the bills of multiple physicians out of a single DRG payment received from medicare.

Second of all, given the risk and hassle of dealing with other physicians, we would expect that assignment rates for DRG packages would fall. And such an outcome would leave the medicare program with the worst possible of both worlds, paying the physician considerably more than necessary when the case is assigned, and the beneficiary paying considerably more out-of-pocket when the case is not assigned.

You as policymakers could deal with this in one of two ways:

First of all, you could mandate assignment for packaged services. We believe heavy reliance on medicare patients for many physicians would keep them from dropping out of the program. Dr. Cromwell and I are the authors of the HCFA study that Dr. Todd cited, and we differ in our interpretation of the findings.

First of all, the majority of physicians did report they would take none of their patients on assignment if forced to choose. But these also happen to be the physicians with small medicare caseloads to start with, so that the net effect on the total supply of assigned visits, while negative, is quite small, certainly not the dramatic decrease that Dr. Todd cited. Assigned visits with all 6 percent, certainly not a dramatic difference.

Second of all, those numbers are based on physician self-reports. And we know from anecdotal evidence provided by Blue Shield plans that when this kind of all or nothing decision is forced on physicians some physicians do, in fact, walk out of the program. But they are back weeks or months later saying, let me back in because I am losing my patients.

There is an alternative to mandatory assignment that you can consider, and that is to hope that the competitive market works, with higher out-of-pocket costs incurred by nonassigned patients encouraging them to switch to physicians who do take assignment.

We believe that switching would be limited, however partly because of supplementary medigap insurance, but also because of the acute one-time nature of many hospitalizations. Beneficiaries simply will not know ahead of time whether the surgeon or attending physician is going to take the package on assignment.

Right now, we know very little about any of these packages and how they might work. For example, our preliminary research shows that physician weights would be very different than the hospital weights currently being implemented under the prospective payment system. These and other issues are currently being studied in more depth by HCFA.

But answers to other questions remain unknown. We do not know whether physicians would cut back on truly necessary services or whether they would just become more efficient in their treatment of patients. And we do not know to what extent shortfalls caused by physicians dropping out of the medicare program would be offset by other physicians expanding their caseloads, especially in a period of increasing physician supply.

To answer these and other questions, we recommend that a prospective demonstration project be conducted.

Thank you.

Chairman **Heinz**. Dr. Mitchell, thank you very much.

On that point, when you say a prospective demonstration program, you are saying test the DRG's in a certain place?

Dr. **Mitchell**. That would certainly be the ideal way. In order to be successful, I believe such a project must be mandatory and not voluntary. Otherwise, the only physicians that would participate are those that thought they would make a profit.

Chairman **Heinz**. How long would such a test take to implement and develop the data base for a thoughtful and adequate evaluation?

Dr. **Mitchell**. I think it would take several years, possibly as long as 5 years, to do that. And given the current fiscal problems, that seems like an unreasonably long time.

I think that there are alternatives, alternatives besides a fee freeze, and one of them would be to adopt special fee packages that could be implemented within a year. They are much simpler and would be easier to implement. They are also of a narrower scope, but similar in some ways to physician DRG's and thus might themselves provide some information to policymakers on how physicians might respond to a physician DRG program.

Chairman HEINZ. How much do we know about special procedure packages right now?

Dr. MITCHELL. All we know is from work that we have done in Michigan and South Carolina, which was performed on a limited set of special procedures. A group would need to be established, composed of physicians representing the different specialties. This group would decide which procedures are appropriate for this packaging arrangement, and what related procedures should be associated with them.

Chairman HEINZ. The concept of special procedure packages is not something I am terribly familiar with.

Does it require, for example—could it work without mandatory assignment?

Dr. MITCHELL. Like any other packaging approach, I think you'd get more for your money if you mandate assignment at the same time that you impose the packages. But, no, it is not necessary. It would be possible to reinforce some cost control incentives which would otherwise be diluted without mandatory assignment. You could introduce incentives directed towards the patient, to encourage the patient to switch, or introduce incentives to the physician to encourage him to accept assignment, such as a fee differential.

Chairman HEINZ. And I gather if you went to a physician DRG system, the kind that you would need to test for several years, 4 or 5 years, you would almost assuredly have to have mandatory assignment in order to really test that; is that correct?

Dr. MITCHELL. I think that if you want to test the full extent of cost savings that would be achieved, you would need to have mandatory assignment. But I think a reasonable alternative is to substitute incentives directed to the beneficiary or the physician.

Chairman HEINZ. When you are saying you could combine those kinds of physician DRG's with some beneficiary cost sharing, presumably give the beneficiary an incentive to improve—to become a better, wiser, more intelligent consumer of health care services—are you saying that that knowledge could somehow substitute for mandatory assignment?

Dr. MITCHELL. What I meant by beneficiary incentives was lower cost sharing for assigned services in order to encourage beneficiaries to switch to a physician who would accept assignment.

Chairman HEINZ. Thank you.

Let me ask Dr. Delbanco and Susan Babin, you are innovators, you are working with this new fee structure. How about charging into the future? Would Massachusetts be a good State to test DRG's for doctors?

Dr. Delbanco, what do you think of this idea?

Dr. DELBANCO. I think it is an extremely interesting, and quite unlikely, unworkable idea.

Chairman HEINZ. We will put you down as having reservations.

Dr. **Delbanco**. What they have done is to take a theoretical example and apply it to existing data. But what they have not done is put it in the real world in which we practice. I doubt I should spend most of my time negotiating with anesthesiologists and surgeons about what she or he and I are going to charge the patient, rather than spend my time with the patient.

Chairman **Heinz**. It might give doctors a tremendous incentive to try to improve their human relations skills.

Dr. **Delbanco**. We already communicate well with doctors, but we have to do better with our patients.

Chairman **Heinz**. If you get along with doctors whose charges you have to set, maybe you will get along better with the patients.

You were about to say?

Dr. **Delbanco**. You point out that approach of mandatory assignment, which I am very much in favor of, in particular for the hospitals. I want to point out also that much of the logic in changing incentives comes down to the HMO concept, actually with incentives that keep us from overutilizing services. Massachusetts now has 12,000 patients a month signing up in HMO's. It is an extraordinary change that is happening very quickly.

Chairman **Heinz**. Are these predominantly older people or just average people?

Dr. **Delbanco**. One of the problems with HMO's is that they generally have not been available to the elderly.

Chairman **Heinz**. Partly because medicare has been a tremendous barrier to that.

Dr. **Delbanco**. We really have little idea of how they would function with elderly patients.

Ms. **Babin**. If I may respond, Senator, from the State's point of view. There are very few elderly in the State's HMO's. And Massachusetts is looking right now at how we can enroll more elderly in HMO's. It has become a priority of the Governor's.

One of the problems right now is the HCFA regulations which have not been promulgated yet. There are some demonstration sites which are to enroll elderly in the HMO's, but except for the demonstration sites, the fact that the regulations have not been promulgated is an enormous obstacle to enrolling the elderly in HMO's.

Chairman **Heinz**. So the problem is it is pretty hard to get reimbursed, among other things, unless the regulations specify the average area per capita cost or 95 percent of what it is going to be, whatever our formula was. I understand.

Well, let me ask this: Dr. Delbanco, you have these modest reservations about physician DRG's. Why wouldn't a combined hospital or physician DRG overcome that particular problem? You wouldn't have to negotiate. I guess it would be the hospital administrator.

Dr. **Delbanco**. I think it is an interesting suggestion. The relationship between doctors and hospitals is changing at an extraordinary rate. If you look back in history a little, doctors have viewed hospitals as places to serve the physicians when their patients needed to come in. But they did not feel hospitals were, or should be, in the business of delivering medical care, as such. Today, if you look at our own program and many others, increasingly, full-time physicians are practicing right in the hospital, and some in organized medicine are frankly quite nervous about that. The suggestion that we take it a large step further, really making it a clear team effort between hospital and doctors, sharing all the financial resources that focus on caring for patients is a fascinating one that's extremely different from what we do today.

Chairman HEINZ. This may be a little bit like saying, would you rather be hung or shot, but if you had to make a choice—notwithstanding Dr. Mitchell's admonition that we ought to test this for 4 or 5 years—between going to a physician DRG concept and a combined part A/part B hospital and physician DRG, which would you go to?

Dr. DELBANCO. Physician DRG. I think it would just be a bit less complicated.

Chairman HEINZ. Not a big difference, but just enough to choose it.

All right.

Let me ask Ms. Babin: you have been wrestling with these physician fee schedules. And as I understood Dr. Delbanco's and others' testimony, they may be very useful in reducing costs, principally by insurance, so that we don't overutilize certain kinds of high cost services, and that we promote the utilization of lower costs of an outpatient kind of service.

What was the reaction of the physicians in Massachusetts to this new fee schedule? Did they say, "Aha, wonderful, we now have a rational fee schedule after all these years of irrationality by Blue Cross/Blue Shield and medicare," or did they have, like Dr. Delbanco, some reservations towards DRG's?

Ms. BABIN. It has been a very interesting reaction. We increased the office visits by anywhere from 11 to 83 percent. We increased the routine office visit by 83 percent, $11.50 to $21. This may sound low to people who are used to medicare fees, but this is in light of what has been traditionally low medicaid rates.

The 17 surgical procedures that we decreased ranged from a 40-percent decrease to a 59-percent decrease. The reaction is what you would expect. The pediatricians and the internists, and the family practitioners were absolutely delighted. The surgeons were not, and the Medical Society represents, to a large extent, surgeons.

The Medical Society is the professional organization that we deal with. They have exerted a lot of pressure to get us to increase the surgical fees even though in terms of total reimbursement, all physicians stood to gain. The reimbursement overall to physicians was increased by $10 to $13 million. The decrease in surgery was only $276,000.

So all physicians gained under this system because their office visits,were going up. I think that what is instructive is that we have had a lot of informal support from physicians, but I think that what we have done has basically split the medical community. The physicians who are involved in the so-called cognitive services are delighted with this. This puts them in a difficult position vis-a-vis their colleagues, and formal support was more difficult for them.

Even the Medical Society has said that they agree that there should be an increase in office visits, however. I think that everybody would like to see this done without decreases, and that is the crucial problem.

Chairman HEINZ. You said that this has resulted in essentially more for everybody?

Ms. BABIN. Yes.

Chairman HEINZ. I assume that is because probably, like most State medicaid systems and medicaid fee schedules, your State was hopelessly urealistic?

Ms. BABIN. It had been artificially depressed for many years. There had been no increases. When I came to the commission 4 years ago, I felt rather than giving little increases which really mean nothing, we would wait until we could institute a dramatic change and really be able to reward the primary care physicians.

Chairman HEINZ. I would gather that because there is more money being spent, I would assume—I would like to know whether my assumption is correct—that this, therefore, has not created any access or quality care problem?

Ms. BABIN. It is hard to know.

Murphy's law was fully in force when we implemented this system. At the same time that we implemented the system, Massachusetts implemented its MMIS system, and there were some bugs in it, to say the least. Physicians did not get paid, and there were cumbersome forms they had to fill out, and there was a lot of animosity towards the medicaid program. Physicians did threaten to disenroll.

How much of that was due to rates and how much was due to the problems of the medicaid program has been an ongoing controversy. It has only been for the last 3 or 4 weeks that the increases in the office visits have actually been in the physicians' checks.

So we are not really going to be able to know the impact of our rates on access for a while.

The other interesting thing is that the medical society greatly publicized our cuts. There was very little or no mention by them of our increases.

Chairman HEINZ. Dr. Delbanco, in your testimony, in effect you, together with Ms. Babin, having experience with one particular program, medicaid program in Massachusetts, argued that a fee schedule in which fees are related to costs of care would remove the kind of economic bias we now have in physicians' treatment choice.

And you said that such a fee schedule would lead physicians to increase the amount of office care, decreasing surgery and other technically complex procedures with high associated costs. And it is your belief, therefore, that a medicare fee schedule would hold down part B costs. That is correct so far; is it not?

It would seem to me it would also have an effect on part A costs since the expensive costs that you have identified are hospital based? Anytime you get a physician into a hospital, you get more than part B charges. You get part A charges.

Now, if, in fact, we direct reductions in part A costs, that's an indication to me that doctors are doing too many procedures as well as doing procedures that are unnecessarily complex, lengthy, expensive; is that correct?

Are doctors delivering necessary as well as unnecessarily costly medical care?

Dr. **Delbanco**. I spent a year here in Washington about 6 years ago, working on both sides of the Hill with Congressman John Moss and Senator Bob Dole. While I was with Mr. Moss, I investigated Blue Shield, and it has been suggested since that I not return to Washington to undergo open-heart and various surgical procedures.

We found instances of honorable, highly regarded physicians doing things that most of them, if they sat down and reviewed textbooks, would argue are not very rational. For instance, one physician ordered something called a sedimentation rate, a blood test, on virtually everyone who visited his office.

There are auditors in Massachusetts for Blue Shield making unannounced visits to doctors' offices because their monitoring system, as Professor Reinhardt rightly suggested could be established, indicated that there were at least questions about how many tests or admissions were appropriate.

The trouble with pointing these instances out is that everyone assumes immediately that all doctors are practicing that way. Ninety-five pecent are probably not, but there are clear examples of when this happens. Just as doctors are nervous about economists, economists are equally nervous about us. We do not practice according to a clearly economic model. We do not try as hard as possible to maximize our income. Economists find that we appear to wake up January 1 and say, "it is reasonable to make *x* dollars this year, and that is what I want to do." Physicians then arrange their lives in such a way that it comes out that way.

I am told I can make an awful lot more money if I just wanted to follow the principle of maximizing income. The current reimbursement systems make it even more crazy, because the doctor has to spin off a lot of tests, cardiograms, or what have you, to reach that "target."

Chairman **Heinz**. In Massachusetts the fee schedule in medicaid resulted in aggregate increase in costs where physicians' fees were involved. By whatever method one uses, whether it is negotiation, whether it is based on some modeling approach, would a fee structure established by some means other than reasonable and customary and prevailing, the current fee-for-services system, result in an increase, an aggregate increase, in physicians' fees, as it did with medicaid in Massachusetts?

Dr. **Delbanco**. I do not know.

One of the reasons I have trouble guessing is, as I alluded to in my testimony, we do not know what is going to happen with all these doctors around. That is the really big problem.

For instance, again, if I think in odd or even numbers, it can affect the costs of medical care in an incredible way. I have no idea really how often to see you in a year if you have high blood pressure. There is no textbook that says it is proper to see the patient every 3 months, every 4 months, every 6 months.

Apparently some nations teach their children to think in odd numbers, and others in even numbers. If I told my patient to come back in 4 months, rather than in 3 months, that can have incredible implications——

Chairman HEINZ. It is called a 25-percent increase.

Dr. DELBANCO. Now, if you have a lot of extra doctors out there who are not as busy as they would like to be, which is certainly happening in a lot of metropolitan areas already, and are debating whether to see you in 3 months or 4 months, I could quickly guess what the consequences might be if we still work on the same incentive system we have.

That would have a similar impact on customary, prevailing, or negotiated fee schedules, or whatever fee-for-service system we have.

Chairman HEINZ. Let me ask: conceptually HMO's and capitation is the easiest solution.

We just haven't found a way to get at all the doctors and hospitals and providers, get arranged neatly in that, and sort of change the nature of our society into something very, very different, I don't know quite how we get from here to there without giving the term mandatory assignment a whole new meaning. Which probably goes beyond the scope of this hearing.

Let me ask you all this last question set.

On Tuesday, the Senate Finance Committee, on which I also happen to serve, is going to put to bed a few modest little changes having to do with part B of medicare. As far as I know, anything that saves money in part A is all right with our chairman as well. Is there anything we should do or not do next Tuesday to save a little money for the Federal Government?

Dr. Delbanco, do you want to be a Senator for today, or at least for the next 3 or 4 minutes?

Dr. DELBANCO. I think changing incentives on the inpatient side is something you should consider. I would favor freezing rates charged by physicians caring for hospitalized patients. You also have an extraordinary opportunity to not only do some quick band-aid surgery, which we need, and I think you feel we need, but you also have an opportunity to begin to mount some of the experiments that have been alluded to today.

Chairman HEINZ. That is my second question.

What do we need to do quickly, as soon as possible, to set a long-term reform in motion?

Dr. DELBANCO. Well, I think you should be receptive to those who come and say, "Let's mount an experiment in this State and try such and such." We have experiments right now on the hospital side in Massacusetts. We have, as you know, what we call chapter 372, a very interesting experiment. None of us know now how it will work out, but it may be that 3 years from now the Nation will decide that is a better way to go than DRG's.

There are a lot of creative, interesting proposals that I hear about, and I think one of the important jobs in the Government is to make it easy for them to, at least, be tested.

Chairman HEINZ. Are you suggesting that OMB is being a little slow in granting of waiver authority?

Dr. DELBANCO. I am a doctor, not a politician. I do not know.

Chairman HEINZ. Dr. Delbanco, I am shocked at that statement. You have been on the Hill.

Dr. DELBANCO. I think it is hard to get the administration to try an experiment sometimes when they may have preconceived no-tions of how it will come out. A true experiment should not carry that notion.

Chairman **Heinz**. Is there anything that the committee's jurisdiction in Congress should do about that? Can we move horses and make them drink?

Dr. **Delbanco**. Well, I think I might hold a hearing for the Health Care Financing Administration to discuss with your committee what innovative approaches to cost control they were trying. I think it would be interesting to have such a public airing.

Chairman **Heinz**. Any other things we should be doing in the long-term, or to set the stage for some new developments in trying to make sure that intelligent experiments are conducted?

Dr. **Delbanco**. I think it is terrific that you are informing the public of these issues, airing them, making it clear what the elderly ultimately face.

Chairman **Heinz**. Ms. Babin, do you have any changes for us over a long term?

Ms. **Babin**. I feel very strongly that any cost containment has to be accompanied by some form of mandatory assignment, because I think otherwise you are just shifting the burden to a population that is less able to carry it. I am not optimistic about the competitive market working in the health care field. We have not seen it working up until now, and there is nothing that would lead me to believe that all of a sudden it would start to work.

I am very nervous about cost cutting techniques for medicare without the assignment issue being dealt with. I think that is a real problem.

Chairman **Heinz**. Dr. Mitchell, any parting shots or closing advice, as the case may be?

Dr. **Mitchell**. Yes.

I would strongly recommend that you and the committee consider more innovative approaches than have been considered to date, that examples like the fee freeze have been tried before under wage and price controls, and we know what happened then. Attempts to supplement fee with utilization review or PSRO's have been similarly ineffective.

I think now, a time of fiscal crisis, gives you a unique opportunity to not only consider some innovative approaches to physician reimbursement, like packaging. I think that you have a much greater chance of actually seeing some true long-run cost savings achieved, which could be far greater than what you could ever have hoped to gain from a fee freeze.

Chairman **Heinz**. Are there any authorities that we need to confer with, let's say, individual States, to work on any of these problems?

I understand that it would be very helpful for us to make sure that the medicare waiver authority in the law perhaps is utilized.

But is there anything beyond that which we need to put into law to allow for State experimentation?

You mentioned the Michigan and South Carolina experiments with special procedure packages. Is there anything we need to do to help States help us?

Ms. **Babin**. I think the HMO at least at this point seems to be something that is up and working. And I think that any assistance that you could give on a very specific issue—getting those HCFA regulations promulgated—would be valuable. It is important for HMO's to be able to contract with medicare.

Chairman HEINZ. I certainly agree with you.

I have just one last thought for all of you, other than the fact that you have been extremely generous with your time, extremely helpful to all of us.

We often cannot think of the SMI program part B being a little different than part A. In the sense, if you will, all operating rooms are created equal. All doctors, operating are not. It is probably true people who are reasonably well-to-do and better educated over the course of their lives select better doctors, who also tend to be at the upper range of reimbursement and presumably also submit a few unassigned claims.

We talk about mandatory assignment. To a certain extent, the idea behind mandatory assignment is in a sense regressive, in that it will shut down what is an informal means testing of the program. And there is an interesting problem, therefore, about how we deal with the issue of people choosing higher priced doctors and reimbursing them. Under the current system, what can we do about that, short term, if we are not going to go to physician DRG's? Should we ignore?

Senator Durenberger has an interesting proposal. He says what we ought to do is lower the premium to 20 percent from the current 25 percent, place a surtax of adjusted gross income that is the equivalent apparently to 1 percent of adjusted gross income, to pay part of the part B costs.

Do those ideas have any appeal to you? Are they irrelevant to this discussion?

Dr. MITCHELL. Well, it's certainly one approach.

Again, it places the burden back on the beneficiary. And I am not sure that that should be the focus right now.

Chairman HEINZ. It distributes the burden differently among beneficiaries. It is designed to be income neutral so it is not immediately clear to me that it puts more burden on the beneficiary as opposed to distributed differently. I am not sure that it has any long-term effect on costs. It could, though. It could bring fees into greater and narrower range.

Dr. CROMWELL. It sounds like it addresses the equity issue of beneficiaries, the rich and poor, and having the wealthier pay more for the program, which sounds like a very positive thing. Again, it does not get at the basic problem, which is the high inflation in the sector, and particularly the increase in the quantity of services.

Chairman HEINZ. Recognized.

Dr. CROMWELL. And so it certainly is an important component, but not really getting at the problem of pricing.

Chairman HEINZ. Dr. Mitchell, Ms. Babin, gentlemen, thank you very much.

You have been extremely helpful to us.

Thank you for your time and your excellent contribution to our hearing.

The hearing is adjourned.

[Whereupon, the hearing was adjourned at 12:45 p.m.]

APPENDIX

STATEMENT OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION

Introduction

The Blue Cross and Blue Shield Association appreciates the opportunity to contribute to this committee's consideration of alternative methods of paying physicians under medicare. In the private health insurance market, Blue Cross and Blue Shield Plans have designed and administered physician payment arrangements to provide medical and surgical benefits to nearly 65 million subscribers. Plans also act as part B carriers for approximately 16 million medicare beneficiaries. In this capacity, they administer physician payment policies designed by Congress and the administration.

Medicare's current approach to paying physicians has served reasonably well the goals of giving medicare beneficiaries access to needed, high quality physician care. Specifically, it has limited beneficiary liability for covered services to required deductibles and coinsurance for a majority of part B claims; it has maintained free choice of physician; and it has limited Federal rates of payments to physicians. Now, however, large budget deficits and concerns about the solvency of the social security trust funds are confronting public decisionmakers with hard choices. How are the medicare program's objectives of financial protection for beneficiaries and free choice of provider to be balanced against the urgent need for cost containment? It is also timely to consider whether the medicare payment system for physicians should be modified to reinforce the cost containment incentives established by the DRG system.

It is our perception that the more radical physician payment alternatives will not prove feasible soon, given the goals and expectations of the medicare program and the current characteristics of the physician service delivery system. Moreover, no payment approach that affords any meaningful level of beneficiary protection and choice is likely to achieve major savings for medicare in the short term. Most of the savings that are practically achievable are likely to come through means other than changes in the basic method of payment, including:

—Continued reasonable controls on rates of increase in unit payments to physicians.
—Shifts in hospital utilization; and
—Stengthtening of mechanisms for assessing the efficacy of technologies and establishing appropriate levels of payment for them.

Policy Objectives and Program Changes

Payment methods are means, not ends. Not only must they exhibit due regard for environmental realities, they must serve specific program goals. Broadly stated, three major objectives for part B of medicare have emerged since its adoption in 1965. They are:

—Supporting beneficiaries' financial access to necessary physician services without explicit regard for variations in beneficiary resources.
—Maintaining unconstrained choice of provider; and
—Controlling program costs.

To deliver all three objectives simultaneously requires a difficult balance of reasonable physician payment levels, experienced administration, sound benefit design and, especially, good working relationships with the physician community. For medicare, the issue has become what tradeoffs among objectives can be made.

KEY POLICY ISSUES

The Congress faces a number of significant policy issues in evaluating reforms in physician payment. These include:

—What expenditure is required to maintain beneficiary access to the preponderant majority of physicians, and what payment methodology best distributes that expenditure.

—The acceptability of the variations in payment level by region, by type of service and by specialty of physician.

—What assignment policy reinforces payment methods in pursuit of program objectives; and

—How medicare should decide whether and what to pay for specific technologies.

UNIT PAYMENT LEVELS

Medicare establishes payments to physicians using the CPR (customary, prevailing, and reasonable) method. This approach has similarities to private UCR (usual, customary, and reasonable) systems. Since the program began, steps have been taken to control increases in payments to physicians. Early on, the limit on medicare payments to physicians dropped from the 90th to the 75th percentile of the prevailing range. In addition, the Medicare Economic Index, enacted in 1972, has been employed to keep physician payment increases in line with general inflation as reflected by changes in general earnings and physician practice costs.

Further limits on physician payment pose two risks for the program. First, they could undermine physician acceptance of assignment. Second, there is some evidence that such action could promote increases in service volume and service intensity. This could negate the savings expected from unit price control. Hospital management has new incentives under the DRG-based prospective payment system to install effective utilization control systems. This should influence postively physican utilization patterns. How strongly they will respond remains to be seen.

Blue Cross and Blue Shield Plan experience may provide some insight into this question. Many Plans are taking a hard look at their unit payments for various physician services. In a few cases, the decision has been made to adjust these unit payment levels as a way to contain costs. In most cases, however, Plans have decided that unit payments are not the key problem. These Plans have, instead, focused on patterns of medical practice. New cost containment programs (e.g. preadmission certification, second surgical opinion, benefit redesign, patient care management) are being instituted to address inappropriate use of services and specific sites of care. A number of Plans have initiated new contractual or participation arrangements with physicians to reinforce Plan payment and utilization programs.

PAYMENT DISPARITIES

Although the reduction of certain payment disparities (e.g., cognitive/procedural, regional) has considerable philosophical appeal, such realignment involves both technical complexity and equity considerations. The acceptability of any realignment, we assume, requires that it promise budget neutrality if not budget savings. For example, increased payment for cognitive services would be contingent on decreased payments for procedures.

Geographic payment disparities may be reduced under either a CPR or fee schedule system. For example, under CPR, annual rates of increase in the prevailing range in higher cost areas could be limited relative to those for lower cost areas. Alternatively, increases in a charge area could be disallowed when they would bring the area to more than 25 (or some other) percent above a regional average. Consolidation of charge areas within a state could also be used to reduce regional variations.

Disparities by type of service could be addressed by designing a fee schedule or variably adjusting the tops of the CPR range for selected charge categories. Budget neutrality necessarily implies lower levels of payment for some physicians under this approach than would otherwise be the case. Negatively affected physicians might become less willing to accept assignment and more inclined to increase service intensity unless there were offsetting positive incentives or controls.

ASSIGNMENT

The major benefit of assignment is that it limits beneficiary liability. Higher assignments rates per se would not reduce Government's expenditures, but they would enhance the value to beneficiaries of this spending. Higher assignment rates could also cushion the effects of further increases in part B. premiums.

Several types of changes in assignment are possible including:

—Mandatory assignment for physicians providing inpatient care.

—Elimination of the claim-by-claim assignment option in favor of a voluntary all claims/no claims assignment approach; and

—New incentives for assignment including higher levels of payment, reduced beneficiary cost sharing, administrative incentives, and Government "marketing" of providers through such means as consumer directories listing physicians by assignment category.

In considering mandatory approaches to assignment, it is important to keep in mind the possible negative consequences for beneficiaries. Physicians generally are not as dependent on medicare for income as hospitals are. Medicare accounts for over 40 percent of hospital revenues but less than 20 percent of physician income, although the importance of medicare payments varies substantially by type of physician. In the main, physicians are better situated than hospitals to reject stringent medicare terms. Large scale rejection would either leave beneficiaries exposed to substantial financial risk or limit their access to physicians.

Designing a policy to increase assignment rates requires an understanding of, first, why doctors do not take assignment for almost half of all part B claims and, second, what can be done about it. One major problem with medicare's assignment policy is that the beneficiary deductibles confuse physician calculations. Have they been filled or not? If not, then the first claim a physician accepts assignment on may be unproductive and may translate into bad debt. Even if the patient eventually pays, administrative costs increase.

Finally, physicians generally face weak incentives to accept assignment on all claims. Claim-by-claim assignment undercuts the noncash incentives for assignment (e.g., guaranteed and reasonably prompt collections, good patient relations) and puts a greater burden on the attractiveness of the level of payment. Also, claim-by-claim assignment undercuts a major marketing advantage of assignment—the implication (not always correct) that the physician who does not take assignment is a high charger. One response would be to strengthen incentives by going to a voluntary all claims/no claims assignment option, and then aggressively publicizing these "participating" doctors.

There is some concern that medicare may find the elimination of the claim-by-claim option too risky. The ability of a voluntary "all or nothing" approach to maintain or increase assignment levels is contingent on several factors. One study of what would happen if the claim-by-claim option were eliminated estimated a 10-percent drop in claims assigned. This study, however, used 1976 data. The world has changed since then. Physician supply has increased significantly; many more HMO's are competing with fee-for-service plans; many Blue Cross and Blue Shield Plans have strengthened their physician participation agreements; and preferred provider arrangements are confronting physicians with new challenges. Given these developments, it is appropriate for HCFA to restudy the potential effects of an elimination of the claim-by-claim assignment system.

A reasonable minimum step may be to maintain the option of claim-by-claim assignment, adding the additional option for physicians to agree voluntarily to accept assignment on all claims in return for HCFA's publicizing their willingness to do so. To reinforce physician acceptance of assignment for all claims it may be necessary to (a) significantly increase the availability of information about physician assignment status, (b) encourage consumers to ask physicians about their status; and (c) work with consumer groups, physician organizations and other parties to promote the assignment concept. By strengthening the implicit "marketing" of physicians who take assignment, the Government and beneficiaries can get more benefit out of the concept.

TECHNOLOGY

Payment of new technology is a difficult and complex policy issue. Very briefly put, there are two basic issues. The first is whether to pay for a new technology. The focus here is on the assessment of efficacy. On this front, the ongoing evaluations of a public/private commission may be valuable for public and private payors, providers and consumers generally. The second issue is what to pay for technologies. Here, decisionmaking should be dealt with by HCFA on a medicare-specific basis. This involves pricing new technology to reward the developmental effort and then adjusting payments downward as new technologies become more routine and less demanding. The feasibility and fiscal impact of this sort of payment change has not been much investigated.

UTILIZATION

Effective utilization review is an essential component of any cost-containing benefit plan. The specific character of a utilization review program must be designed to reinforce the strengths and protect against the weaknesses of whatever physician payment is used.

SPECIFIC PHYSICIAN PAYMENT METHODS

CPR (CUSTOMARY, PREVAILING, AND REASONABLE)

The strengths and weaknesses of the CPR method of payment are reasonably well understood. The ease with which it can be adapted to serve new purposes may not be adequately appreciated. The method, as currently administered by part B carriers, reflects significant specialty and geographic variation in payment levels. Congress can constrain this flexibility without changing the basic method. For example, screens can be imposed to reduce regional and specialty variations over time. As mentioned earlier, regional variations can also be reduced by requiring that larger geographic units be used in determining prevailing ranges.

Already, with the constraints on payment increases imposed by the Medicare Economic Index, the often-criticized link between the CPR method and physician charging practices has been substantially curtailed. Moreover, the CPR payment approach has achieved assignment on just over 50 percent of the physician claims. On the other hand, in the absence of high levels of assignment, the CPR method makes it difficult for beneficaries and physicians to predict beneficiary liability for charges beyond allowed Medicare payments (plus deductibles and coinsurance). Higher levels of assignment and assignment on all claims/no claims basis would also increase predictability.

SCHEDULE OF PAYMENT

A payment schedule establishes a maximum payment for medical and surgical procedures and encounters. One advantage of a payment schedule is that it can facilitate price shopping. If medicare beneficiaries know the schedule payment for a given service, then, at least in principle, they can check and compare physician's actual charges with those of other physicians and with medicare payment.

Like other fee-for-service payment methods, the schedule approach is vulnerable to provider manipulation of utilization and service intensity (including the labelling of procedures or encounters in ways that maximize payments). Another consideration is that if the method departs too dramatically from market rates, its acceptability to providers and beneficiaries will deteriorate. It will then fail to meet its financial protection and access objectives.

Change to a payment schedule would involve a variety of start-up problems. A key difficulty would be how to set the schedule levels high enough to attract physicians in the existing 50th to 75th percentiles without incurring major costs by automatically pulling up payments to those in the 1st to 50th percentiles. One approach would be to pay the lesser of physician charges or the schedule maximum. However, maintaining such a differentiation over time—even for a short transition period—would require controlling rates of increase not only for the schedule but for charges below the schedule. That would essentially continue CPR in tandem with a schedule.

An alternative would be to establish a schedule that would be budget neutral assuming physician charging would not change. In fact, however, charging practices would change. Most charges below the schedule level would move up, and some above this level would move down. An upward shift would cost both medicare and the beneficiary money; in contrast, a downward shift of charges toward the schedule would be irrelevant to the trust fund but might reduce the extra balance billing liability that beneficiaries incur. This liability would be affected by the impact of incentives for physicians to accept assignment. The full implications of various transition alternatives need to be carefully studied.

Fee schedule with physician participation/assignment

Like a CPR or UCR system, a schedule of fees can be combined with new physician assignment incentives. From a public policy perspective, the purpose of assignment or similar arrangements is to limit beneficiary liability to the level of cost sharing specified in the law. In the private sector, programs that successfully contain patient liability establish reasonable levels of payment to attract and maintain significant physician participation. Some Blue Cross and Blue Shield Plans are attempting to strengthen the cost containment effects of their agreements with physicians not by cutting unit payments but by strengthening "hold harmless" and utilization review provisions. Whether medicare can achieve higher levels of physician assignment is an important question in assessing how beneficiary liability might be affected by adoption of a medicare fee schedule.

Schedule of indemnity benefits

Some insurance arrangements establish payment schedules that have no particular relationship to the physician's charges or the beneficiary's liability. This approach frees a payor from the need to maintain payment and other terms that attract enough physician participation to deliver a defined liability or a full service benefit. For that reason, indemnity schedules are often associated with low benefit plans. It does not appear politically feasible or socially desirable for medicare to adopt an indemnity schedule.

PER-CASE PAYMENT

Congress could seek the objectives of both limited beneficiary and limited Government liability for health care costs through physician payment methods that put physicians at greater risk for their practice patterns that do conventional fee-for-service approaches. Case-based payment, analogous to the DRG-based prospective payment system for hospital services, involves such a risk shift. A limited version of such an approach is already in place through the use of global fees for most inpatient surgical procedures (these include the surgeon's provision of pre- and postoperative care). However, the applicability of per-case payment for much outpatient care, for non-surgical inpatient care, and for care involving several physicians or other direct billing professionals is virtually untested.

Some of the difficulties with per-case are technical (e.g., defining what constitutes a case of different types of inpatient or outpatient medical services). In addition, concern about quality of care arise because per-case payment contains economic disincentives for concurrent care, consultations and changes of physician when the patient is dissatisfied. Given that medicare's new hospital payment method contains potential incentives for underservice, there are risks in reinforcing this direction by adopting per-case payment for physicians. The basic point is that case-based payment for medical, as distinct from surgical care, is an unknown quantity. No large-scale experiment has been attempted, and the differences in hospital and physician services preclude generalization from hospital-based experiments. Once developed with some degree of conceptual plausibility, per-case payment merits testing through demonstration projects.

CAPITATION

A variety of options for part B capitation exist. All care may be capitated, or primary care alone may be capitated, with specialist care paid using a fee schedule or CPR. The capitated payment may go directly to physicians, or it may be directed to any organization such as an HMO or a Blue Cross and Blue Shield Plan. The organization then pays individual physicians on a salaried or fee-for-service basis. Some sort of risk-sharing pool for physicians may be established as an incentive for economical provision of care.

To date, the successful implementation of capitated payment for physician services has been closely tied to organzied physician practice arrangements, such as multispecialty group practices contractually linked with HMO's. Such arrangements, when they involve an identified or enrolled population, provide the administrative capacity and operational scale needed to manage risks, balance objectives, and average out or absorb variations in enrollee health status and other factors outside an individual physician's direct control.

Medicare demonstration projects have already enrolled beneficiaries in HMO's and similar organizations. These more comprehensive systems are probably a workable option for the medicare population. Evaluations of these projects, however, are not yet complete; they should provide valuable information about the specific advantages and limitations of capitated payment. In particular, careful cost comparisons with the traditional medicare program (controlling for risk selection) are needed to assess the fiscal impact of the HMO approach.

Near-term alternatives differ from long-term options. In the long term, it may become feasible to rely on competition within the total medicare program to reduce cost increases. The results of the demonstration projects and the impact of TEFRA's new HMO/CMP reimbursement policies will indicate the feasibiliy of this strategy.

SUMMARY

We believe that it is most timely to consider options for reform of medicare physician payment in order to improve incentives and increase the number of physicians who take assignment. As the medicare part B program has evolved, three major objectives have emerged: financial protection for beneficiaries, free choice of providers, and the control of program costs. We believe that physician payment reform options should be evaluated against all of these objectives. This presents the Congress with difficult choices and tradeoffs. For example, in our view, no payment approach that affords any meaningful level of beneficiary protection and choice is likely to achieve major savings for medicare in the short-term. Also, in reviewing specific options to improve the assignment rate, it is important to consider whether any proposed alternative to the present system provides adequate safeguards that beneficiaries will continue to enjoy reasonable access to physicians. Finally, we would note that, in the long-term, it may be feasible to make major structural reforms to medicare physician reimbursement and rely on competition to meet the program's objectives.

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